CHILD ABUSE: WHAT WE KNOW ABOUT PREVENTION STRATEGIES

HEARING

BEFORE THE

SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

SECOND SESSION

HEARING HELD IN WASHINGTON, DC, ON
MARCH 12, 1984

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CHILD ABUSE: WHAT WE KNOW ABOUT PREVENTION STRATEGIES

MONDAY, MARCH 12, 1984

House of Representatives,
Select Committee on Children, Youth, and Families,
Washington, DC.

The selectcommittee met, pursuant to call, at 9:30 a.m., in room 2261, Rayburn House Office Building, Hon. William Lehman (chairman of the Prevention Strategies Task Force) presiding.

Members present: Representatives Lehman, Anthony, and Bliley.

Staff present: Alan J. Stone, staff director and counsel; Ann Rosewater, deputy staff director; Karabelle Pizzigati, professional staff; Marcia Mabee, professional staff; Donald Kline, senior professional staff; and Joan Godley, committee clerk.

Mr. Lehman. The Select Committee on Children, Youth, and Families Task Force hearing on prevention strategies on the subject of child abuse will now come to order.

I am pleased that all of you could join us for the first hearing in 1984 of the Task Force on Prevention Strategies of the select committee.

This morning we will focus our attention on what we have learned about strategies to prevent the terrible tragedies of child abuse and neglect.

Throughout the committee's first year, we heard a great deal about the increasing problem of child abuse and its toll on child victims, their families, and society at large. In our Washington and regional hearings, witnesses told us about dramatic upswings in reported and confirmed cases of physical and sexual abuse of children in recent years. Many States have documented large increases, and nationwide, reported abuse was up more than 100 percent between 1979 and 1981. The number of child abuse related deaths also rose nationally last year.

We are experiencing an epidemic, with more than one million children suffering abuse every year and concomitant increases reported in the severity of abuse. In my growing multicultural area of Florida, I am hearing more and more about the problems and the need for greater and more coordinated action.

Public awareness of these problems is growing rapidly too. But, at the same time, declining resources have made it more difficult for everyone to combat child abuse. In fact, there are in many cases so few resources available that we can barely respond to and treat crisis situations, much less engage in systematic approaches to prevent abuse—approaches that could strengthen families in a variety of ways and be significantly more cost effective in the long haul.

We, by no means, have all the answers. But there is fortunately a growing base of experience and knowledge about effective ways to help families prevent abuse and treat parents and children in situations of identified abuse to prevent reoccurrences. The committee learned about some of these in our hearings last year.

Today we will continue our examination of a wide range of prevention issues and strategies that must be considered in order to confront the major public health and social problems of child abuse more effectively.

That concludes my statement, and Mr. Bliley, the ranking minority, may have a statement.

Mr. BLILEY. Thank you, Mr. Chairman.

I want to thank you particularly for scheduling this hearing. I want to thank the panels of witnesses who will appear before us today. We are privileged to have with us many of the leaders of this Nation's battle against child abuse. Indeed, if it weren't for some of the people in this room, there might not be a battle against child abuse in this country; or at least not much of one.

I am especially pleased to see with us several persons who have worked very hard, and very successfully, at inspiring and mobilizing large numbers of volunteers, both professional and nonprofessional, to join the fight against child abuse. The National Committee for the Prevention of Child Abuse, Parents Anonymous, and Parents United are composed of thousands of volunteers, all dedicated to improving the lives of children and their families.

Indeed, Parents Anonymous and Parents United seem to represent the ultimate in volunteer efforts. The self-help concept which they employ has been the most successful in decreasing the incidence of child abuse, and stopping its cycle. And the way that it does this is one of most fascinating and inspiring accounts that I have heard: it takes people whom the rest of society is ready to give up on, and gives them the ability and the responsibility to help each other and themselves.

The self-help concept recognizes that responsibility is part of humanity and without it, no one can be fully human. By recognizing and utilizing this very important truth about human nature, groups such as Parents Anonymous and Parents United have saved the lives of probably thousands of children; and not only of the children, but of their parents as well.

I welcome here all of our very knowledgeable and dedicated witnesses. I look forward to your testimony. In addition, I would also like to welcome the many Parents Anonymous State coordinators who, I have been told, are with us in the audience today. It is a privilege to have you with us.

Mr. LEHMAN. Thank you, Mr. Bliley.

[Opening statement of Congressman George Miller follows:]

STATEMENT OF HON. GEORGE MILLER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRMAN, SELECT COMMITTEE ON CHILDREN, YOUTH, AND FAMILIES

I would like to commend Mr. Lehman and Mr. Bliley for calling this hearing on behalf of the Prevention Strategies Task Force. Certainly, as we begin our second year of hearings, one of the most important areas for us to pursue is prevention strategies for child abuse.

We have been convinced by the dramatically increasing numbers of abused children, particularly sexually abused children, to act now. Witnesses from Maine to Utah, Michigan to Colorado, have detailed for the Committee the increased severity and frequency of reported abuse cases, as well as the increases in actual numbers of children involved. As a result, there is no disagreement on the importance of the issue, and members of both the majority and minority are anxious to look at the problem in greater depth.

Hopefully, we can build on some of the successful prevention and intervention models already brought to our attention. As we noted in the Select Committee's "Year-end Report":

"Fortunately, the Committee heard about, and learned a great deal from, many of the successful prevention and intervention programs designed to address child abuse in particular.

"In Denver, a home visitor program for 25 high risk families saved over $1 million in medical costs for the treatment of severely abused children.

"In Connecticut, there are several successful prevention models using parent aides, multidisciplinary child protective teams, and Parents Anonymous support groups.

"In Florida, multidisciplinary teams are used to investigate cases of child abuse. The Tampa area hosts an innovative foster home for young mothers at high risk of abuse, and their children, who are cared for by foster grandparents.

"In Duluth, Minnesota, a sexual abuse awareness and treatment program provides support for children who are victims of sexual abuse, as well as a program for elementary school children which helps them distinguish between 'good' and 'bad' touching."

I am looking forward to today's in-depth look at the causes of child abuse, to the personal stories of those who have struggled to come to grips with their own problems as abusing parents, and to learning much from responses of successful volunteer groups, hospitals, and health departments. We have much to learn, and are eagerly awaiting today's testimony. I believe every member of Congress is deeply concerned with doing more to prevent child abuse, and I'm certain the record we create today will be read and studied in the months ahead.

Mr. LEHMAN. Without objection, before your testimony, I would like to insert in the record the statement of the ranking minority member of the full committee, Mr. Marriott of Utah, who is unable to be with us today.

[Opening statement of Congressman Dan Marriott follows:]

OPENING STATEMENT OF HON. DAN MARRIOTT, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF UTAH

Thank you Mr. Chairman. I want to express my personal thanks to our witnesses for devoting their time and resources to be with us today.

My interest and my support for reauthorization of the Child Abuse Prevention and Treatment Act are well known to my colleagues on the Select Committee as well as on the floor of the House. I am proud of the fact that the House has passed H.R. 1904. I regret that the reauthorization of the Act has been so long delayed in the Senate.

Some of the witnesses we are to hear from today are pioneers in the field of child abuse and neglect. Dr. Vincent Fontana was among the first to publish professional articles on the subject. Dr. Fontana's article on "The Maltreatment Syndrome in Children" appeared two decades ago in the highly respected *New England Journal of Medicine.* He was among the first physicians in the United States to bring the problems of abused, neglected, and sexually maltreated children to the attention of his colleagues, the American people and Congress.

One of his early articles to be submitted for the benefit of the hearing record was published ten years before Congress passed the Child Abuse and Neglect Prevention and Treatment Act. The original Act was passed by Congress in 1973. It has been ten years since it was signed by the President to make it the law of the land.

Now, thirty years after the problem was first known to the medical profession and a decade after the first national legislation was enacted, we find ourselves still trying to stem the rising tide of children who are known to be abused, neglected, and sexually maltreated each year.

In Dr. Fontana's 1963 article he cited a study done by Dr. C. Henry Kempe and his colleagues reporting the results of a nationwide survey of hospitals and law-enforcement agencies indicating the high incidence of "battered" children within a one-year period. At that time a total of 749 children were maltreated. Of this number 78 died and 114 suffered permanent brain damage.

We are all aware that it was not until over a decade later that we began to understand the true extent of the problem. Even today we are uncertain about the true number of abused and neglected children because we know the problem is still substantially undetected and unreported.

While we spend billions in the support of families with dependent children (AFDC), programs to improve the housing of poor families and all forms of social. health and educational programs, we still have not supported programs that are known to be successful in preventing the abuse and neglect of children. In short, we are losing the battle. We still fail to prevent child abuse, neglect, and the sexual exploitation and maltreatment of children. If we do not stop the ever increasing abuse, neglect, sexual exploitation and maltreatment of children, the decadence that has long been predicted by historians for self-governing people will certainly come to pass.

It is clear that we still face a massive problem of abuse and neglect. The legislation we have passed has responded to the symptoms of the problem rather than legislation designed to seek out and eliminate the causes.

It is also clear that we have buried the National Center on Child Abuse and Neglect so deeply in the administrative structure of the Department of Health and Human Services it fails to enjoy the support and visibility required. Dr. Frederick Green notes in his testimony that the program he heads, ". . . has been placed sufficiently high in the hospital's administrative and management structure to ensure that it has adequate purview to accomplish its mission." The National Center on Child Abuse and Neglect needs to be given a similar place in the Department of Health and Human Services.

Today the Committee will also hear from others who are recognized as pioneers in the field of abuse and neglect. Dr. Anne Cohn as well as Dr. Frederick Green and Dr. Vincent Fontana are recognized not only nationally but also internationally as experts in the field. Dr. Cohn has been among the leaders in the field of prevention for well over a decade. Drs. Fontana and Green have also been involved in prevention of this phenomenon even longer.

I would be remiss if I did not mention Leonard Lieber's qualifications to appear before this Committee. Mr. Lieber has also been a pioneer in the field of prevention. He has used very modest federal resources to leverage volunteer efforts worth millions of dollars each year to help those who have or fear they might abuse their children. The Parents Anonymous program, using largely volunteers and self-help has changed the lives of many parents who have harbored feelings of guilt, and fear and provided them with a sense of self-worth, dignity, and productivity. We will be hearing from some of the parents during the course of this hearing.

I am proud to have played some small part in the passage of H.R. 1904 to reauthorize the Child Abuse Prevention and Treatment Act, as amended. It fails to provide as much as I would have liked. However, it does continue to provide an essential national focus on the problem and contributes in a small way to the resources made available through the states and to thousands of private volunteers who continue in the battle to save our nation's most valued resource—our children.

It is my fond hope that our colleagues in the Senate will soon consider the companion bill to H.R. 1904—S. 1003—so we can get on with the work remaining to be done.

Mr. Chairman, I want to extend my personal greetings and best wishes to each of our witnesses here today. I wish them every success in their work and I hope this is one area where we will find unified support from our colleagues on both sides of the aisle and in both the House and the Senate.

Mr. LEHMAN. Our first witness today is Dr. Anne Cohn. Would you please come forward? We have a time problem today and your statement, without objection, will be included in its entirety in the record, but it will be almost essential that you do summarize it.

STATEMENT OF ANNE COHN, D.P.H., EXECUTIVE DIRECTOR, NATIONAL COMMITTEE FOR PREVENTION OF CHILD ABUSE, CHICAGO, IL

Ms. COHN. Thank you, Mr. Chairman, members of the committee.

My name is Anne Cohn, executive director of the National Committee for Prevention of Child Abuse. I think it is particularly fitting that you are holding this hearing today. Late last week, Dr. C. Henry Kemp, regarded by all of us as a founding figure in the movement to eradicate child abuse, passed away. Dr. Kemp, the pioneer in the field, who coined the term "the battered child syndrome" and who initiated the first congressional hearing on child abuse in 1973, truly has been an inspiration for all of us. He has made his mark felt. I think this hearing is a great testimony to his work. Two months ago, ABC aired a special made for television movie called "Something About Amelia," which dealt with the issue of incest. Following that movie the National Committee for Prevention of Child Abuse received over 3,000 letters from people touched by the problem of sexual abuse. I would like to share with you the contents of just a few of these because I think that they explain quite well why we are here today:

> Something about Amelia brought tears to my eyes. I was molested when I was 10 and now I am 30 and I still can't deal with it. I have nightmares about it * * * Throughout my life I have all but forgotten about it. What my father did to me has affected every relationship I have had with any man * * *
>
> To whom it may concern: I was molested as a child by my father, my brother and my uncle. The only time my father did it is when he was drunk. My brother and uncle did it, I guess cause they wanted to.
>
> Dear National Committee, I am a 28 year old male that still is induring the pain of incest after 20 years, and the actual victim was not me, but one of my step sisters. This occurred in a small rural community and my Dad was sent to the State prison. Is it common for the brothers of the victim to live with shame, guilt, and low self-esteem?

And finally:

> Dear Friend, one night I was watching TV with my 15 year old daughter. She just started crying. I said: "what is wrong?" She stared at me. I thought it was something I did. Finally she said: "Mom, I have something to tell you. You are not going to believe me but everything I am about to say is true."
>
> I said, "Go on, hon." She said: "Mom, Dad has been making me have sex with him for four years."

We received over 3,000 such letters in the last few months. Many years ago, 1976, when the National Committee first began a national public awareness campaign about child abuse, we received comparable letters about physical abuse and about emotional abuse.

None of these episodes need to have occurred. Child abuse can be prevented if we direct our efforts toward stopping it before it occurs. As a nation we have been aware of the problem over the last decade. In fact, today we know that over 90 percent of the adult population is well aware of the problem, its causes, and its consequences, and in the last decade we have been responding to the problem. We have been responding in a very powerful and important way, although our response has been largely after the fact.

We have developed reporting hotlines, we have developed a capacity to investigate reports of child abuse, we have developed treatment programs, some that are really quite exemplary, such as

Parents Anonymous and other self-help efforts. We have made progress but at the same time, child abuse still appears to be on the rise. As best we can tell, the figures increase year after year despite our efforts to respond after the fact.

Obviously, there are a lot of reasons for this. Unemployment and the prolonged recession have certainly taken their toll. I believe a significant part of the reason is that we have done little to try and stop the problem before the fact.

Why should we be concerned with prevention? We know that over 1 million children each year are abused. We know that well over 2,000 of those children die. Just the pain alone experienced by those children should be enough to cause us to want to stop the problem before it occurs.

But the costs are much greater than that. Each one of those cases costs us, if we are talking about investigative and treatment costs, over $2,000 initially, and the costs are greater later on if children require institutionalization, as those abused children—and this happens to many of them—may grow up to be juvenile delinquents or teenage prostitutes, teenage drug addicts, or perhaps run away from home. It appears that child abuse is really the linchpin of many of our social problems. It appears that child abuse is something that we need to stop in order to save valuable lives as well as valuable dollars.

Can child abuse be prevented? We don't have scientific proof that says it can. I personally believe that it can. The paucity of research done to date doesn't give us the kind of evidence we might like, but the few research studies that have been done point us in some directions that appear to be promising. Our clinical experiences also point us in some directions that appear to be promising.

What I would like to do is take a few minutes to just reflect on what some of the underlying causes are of child abuse, and, therefore, what focus our preventive efforts should have, and then to review what research has told us about those promising avenues of prevention.

Based on what we know about the causes of child abuse, we know that parents who abuse their children oftentimes have an inadequate understanding of child development, an inability to relate to the demands of parenting or an inability to manage their children in ways that appear to be positive. One approach to prevention would be to increase parents' knowledge of child development and their abilities to manage their children.

We know that poor bonds between parents and children are often related to factors associated with child abuse. This is another area in which we would like to intervene. Research has shown us that parents have difficulty coping with infants, and particularly children with special difficulties, infants with special needs, disabled children, and handicapped children. This is another area of focus for our preventive efforts.

The burden of child care, family isolation, lack of peer support are also factors that our research have shown us are associated with abuse. These are additional avenues that we ought to focus on for prevention.

Finally, we know that children themselves often have an inability to protect themselves from abuse, and this is a final area that our preventive efforts ought to focus on.

As I mentioned, our research to date has been fairly slim, very few studies have been funded to look at the issues of prevention. Those studies that have been funded have been relatively short term. They usually have been inadequately funded and have not been able to develop the kind of experimental control group situations that the scientific community would like to see in order to know that the data they yield in fact are meaningful data.

However, there have been a few studies that have been done and I would like to cite them to you:

The first is a study that the National Committee for the Prevention of Child Abuse completed in the last year. It was a 3½-year study of 11 different demonstration prevention programs funded by the Federal Government. This study concluded the following: That if one can provide different kinds of support to new parents, in other words, help to new parents around the time of birth, and around the first year after the birth of the child, that parents can develop much better coping skills with their children, more positive attitudes toward their children.

The study showed that parents that go to education classes, particularly new parents just after a child has been born, can develop more positive attitudes and a better ability to negotiate with their children and provide them with support.

The study showed that very caring people who may not have professional training but are volunteers and want to help out can make a positive difference. Our preventive efforts need not rely strictly on professionally trained individuals.

A study in Denver looked at a home-health-visitors program and showed that that kind of a program which provides ongoing support to parents after a child is born, regular visits to the family, to provide the family with its various needs, can make a big difference in reducing the risk of child abuse.

A study in Nashville, TN, looked at improved birthing procedures allowing rooming in and some other supports around the time of birth and showed that when additional supports are provided to families around the time of birth, things can change and abuse is less likely.

These are a few studies. They provide shreds of evidence about how to approach prevention. They don't convince us of the exact way to go, but they do suggest some avenues.

I think that the experiences that people in the field have had provide much stronger support for the directions in which we ought to go. There is a program called the Parent Linking Project in New Jersey. This is a program that works with teenage parents before they become parents, as soon as their pregnancy is discovered. The program works with them for a full year after their babies are born, and helps them develop coping mechanisms and skills so they can care for their children and also continue to live their lives as teenagers.

Administrators of those programs report remarkable changes in the abilities of the teenagers to care for their children and we know teenage mothers are a much higher risk in abusing their children than are older parents.

There is a program in San Antonio, TX.

Mr. LEHMAN. The teenager parents have more child abuse than older parents?

Ms. COHN. Research evidence supports that, yes.

There is a program in San Antonio, TX, called Project ABC—Any Baby Can—and that is a program for parents of children who have special handicaps or disabilities. Those children just place additional stress on parents and are much harder to cope with, and in that sense, are at much greater risk. The administrators of that program showed, through their own experiences, that providing that kind of special support to parents of handicapped children can make a difference in those parents ability to cope and, therefore, not become abusive parents.

There are a number of other examples. There is a program called Bubbylonian Encounter, which is a play for children that teaches children about different forms of touching, good touching, and bad touching, and forced touching, and forced sexual touching. The experiences of the people in Kansas who developed the play and have taken it around to the schools and shown it to elementary schoolchildren is very positive. They find that when children are exposed to information about different kinds of touching and how to protect themselves and say no to touching that appears to be inappropriate, children can in fact protect themselves from different forms of sexual abuse and perhaps other forms of child abuse as well.

Our experiences are growing. There are a lot of programs across the country, like Parenting Linking, and Project ABC, and Bubblylonian Encounter. There are a lot of programs that are developing now using volunteers, using citizens in local communities working with the schools and hospitals, that are expanding our experience base for the directions in which we might go in order to prevent child abuse.

A number of things are clear from these experiences and from our research. First, there is that there is no one approach that is going to stop child abuse from occurring. There is no magic solution. Child abuse is a very complex problem. In fact it is many problems under one heading. There are many different causes of the problem and in order to prevent child abuse, we really need to direct our resources and our attention to many different things—to new parents, to parents of older children, to young children who have been abused, to young adults who were abused when they themselves were children.

Our efforts in prevention have to include various kinds of support programs for new parents to help them get off to a good start, education for parents so they can develop better skills in dealing with their children.

We need to think about providing better child care for parents, better alternatives for child care so that parents who are burdened by heavy, continuous, child-care responsibilities can get some respite from that.

We need to concern ourselves with helping abused children, helping to break that cycle of abuse so they don't grow up bearing the scars of abuse which often lead them to become abusive parents themselves. We need to think about ways to help children develop skills so they can protect themselves from abuse and so when they grow up they can be better parents themselves.

We need to look at various kinds of self-help strategies, such as Parents Anonymous, but programs that are developed for parents before they have abused their kids, so that they can help each other develop better parenting skills and avoid abuse.

We need to make sure that we have available to all families a variety of crisis hotlines and help lines, crisis nurseries, and other kinds of emergency support so in the moment when a parent is about ready to lash out there is a place to turn for help. So they can get immediate support rather than lashing out at their kids.

We need to think about ways in which we can help prevent child abuse through the workplace. Current research suggests that a tremendous amount of what happens at the workplace affects an individual when they get home. We know that if through the workplace flexible working hours can be provided, child-care support can be provided, people can be provided with a variety of other kinds of counseling and fringe benefits, that these are ways to strengthen the family through the workplace and thereby prevent child abuse at home.

Finally, in our efforts to prevent child abuse we need to look at the media and look at ways in which what happens on television and through radio help provide information to parents and to families to prevent child abuse.

[Prepared statement of Anne Harris Cohn follows:]

Prepared Statement of Anne Harris Cohn, Executive Director, National Committee for Prevention of Child Abuse Chicago, IL

As a result of the January 9th, 1984 airing on ABC of the made for TV movie about incest, Something about Amelia," the National Committee for Prevention of Child Abuse received over 3000 letters from individuals poignantly and personally touched by the problem of child sexual abuse. Nothing has touched me more deeply in my 12 years of working in the child abuse area than the pain and guilt and sadness and trauma conveyed in these letters. A few exerpts:

"Something About Amelia" brought tears to my eyes. I was molested when I was 10 and now I'm 30 and I still can't deal with it. I have nightmares about it . . . Thoughout my life I have all but forgotten it. What my father did to me has affected every relationship I have had with any man . . .

I was molested as a child by my father, my brother and my uncle. The only time my father did it is when he was drunk. My brother and uncle did it, I guess cause they wanted to.

I am a 28 year old male that still is enduring the pain of incest after 20 years, and the actual victim was not me, but one of my step sisters. . . . my dad was sent to prison for it . . . is it common for brothers of a victim to live with shame, and low self esteem?

I am a 36 year old woman. Recently I've begun to deal with being sexually molested as a child . . . by my older brother.

"Amelia" brought up unpleasant memories. I was sexually molested by my adopted father from the earliest time I remember. It continued until my parents divorced at age 12. Til this day my mother does know about it and I am now 27. I was forced to do the most degrading things. I was always told never tell mom! I carry about a guilty feeling with me, wondering what would have happened if I told mom.

I am one who caused sexual abuse within a family. I abused my stepdaughter over a period of several years. My conscience grew until I finally voluntarily exposed my problem and got counseling. But . . . the problem caused my wife to separate from me. I live alone. I have some contact with my family, but am in danger of losing it . . . my stepdaughter has not yet come to grips with what happened.

I have a lot of truth to tell about what occurred and damaged my own childhood to the point of my being sent to the state prison for 15 years. I am not a bad man nor do I want anything from anyone except help for my mental disorder. Please keep an open heart and a mental picture of my problems as a child and the abuse (I later perpetrated) which got me placed behind bars.

In my opinion people who have incest with youngsters are sick. They for sure need some kind of help . . . One night I was watching TV with my 15 year old daughter and she just started crying. I said Krystal what's wrong? She just starred at me. I thought it was something I did. Finally she said mom, I have something to tell you. You're not going to believe me, but everything I'm about to say is true. I said "go on honey." "Mom dad has been making me have sex with him for 4 years."

In 1976 when the NCPCA launched the first nation-wide public awareness campaign on child abuse, we were similarly avalanched with letters from victims and perpetrators of child abuse as well as concerned family members and friends. Most of the letters at that time spoke of the horrors of physical abuse and neglect. Today its sexual abuse. Regardless of the type of maltreatment, I deeply believe that none of these stories had to become reality. I firmly believe that child abuse—in all forms—can be prevented, can be halted before it ever occurs.

As a nation we have, over the past decade, become aware of the child abuse problem. With a small, but highly visible and active Federal program, under the aegis of the National Center on Child Abuse and Neglect, and the vigorous activities of numerous national, state and local organizations, such as NCPCA's ongoing national public awareness campaign, the nation has been awaken. And we have responded. But our response has been primarily after the fact. We have worked hard at identifying cases of child abuse and getting them reported to the authorities. We have expanded and improved our capacity to investigate reports of child abuse and to treat parents who are the abusers. Every state has a 24 hour capacity to receive reports. Law enforcement and Children's Protective Service agencies across the country have developed sounder policies and procedures for responding. Multidisciplinary teams have emerged in most of our communities to assist in triaging cases and in treatment planning.

Parents anonymous groups—shown to be one of the most effective approaches to treatment—have multiplied nationwide; the count is now well over 1000. Parent aide and lay therapy programs to support abusive parents have proliferated as well. While our success rates with treatment programs still remain low—at under 50%—the foundation for a strong response and treatment system, implemented by a growing and increasingly solid knowledge base exists.

This is progress. But only partial progress. For, as a nation, we have all but neglected what I regard as a much more pressing need. It's as if in our efforts to respond to this tragic problem we've become so acutely aware of, we've forgotton to consider how to stop it. Donna J. Stone, founder of the NCPCA, likes to describe her washbasin theory of prevention. "Imagine a washbasin with the stopper down and the hot and cold water running. As the basin overflows, people run to put pails under the sink. Some use buckets to empty the sink. Prevention is stopping the water." When I speak of prevention, which I would now like to do, I speak of stopping the water flow.

Why should we be concerned with prevention? Because every year more than one million children in the U.S. are seriously abused by their parents and over 2000 die and our best information says that these numbers are on the rise. The pain experienced by any of those children should be enough to motivate us to stop abuse before it occurs. But if this is not enough, consider what we know about the manifest and latent effects abuse. Each identified case of child costs society dearly—generally $2000 or more just for an investigation and short term treatment. When a child must be hospitalized or put in foster care or a parent incarcerated, the costs rise significantly. Once the immediate crisis and response to the abuse has passed, there are usually other costs. Abused children suffer a wide variety of developmental, emotional and physical difficulties. Some need to be institutionalized. Others require special education. Some become juvenile delinquents, or teenage runaways, or teenage drug addicts, or teenage prostitutes. Each time this happens, society pays. Not all but a good number of abused child have visible and costly difficulties as adults—as abusive parents themselves or even as hardened criminals. And society pays. No matter how you look at it, child abuse is a lynch pin of many of our other society problems, problems which cost us dollars, and productivity and happiness. The arguments for stopping abuse before the fact are, I believe compelling.

Can child abuse be prevented? Because as a nation our awareness of child abuse problem can still be characterized as fresh and because as a nation our response to date has largely been after the fact, we do not yet have an adequate scientific knowledge base which completely answers the question.

Research efforts in the child abuse area have been relatively meager. Few have focused on prevention. Those which have, because of scant funding and short time frames, have generally not been vigorous or controlled enough in their designs to meet standards of the established research community. And, because of the very complexity of the child abuse problem—it's really many problems with many causes characterized as a single issue—it is not clear to me that we will ever be able to design and implement prevention research which will yield scientifically pure data.

There have been and are efforts which help our understanding of the problem. For examples, the NCPCA completed, in 1983, the first national evaluation of child abuse prevention demonstration programs, a 3 year study which analysed the impacts of 11 diverse prevention strategies and sheds some light on how to prevent abuse.

The study shows, for example, that programs which offer support to new parents, expecially around the time of birth, have been significant in diminishing the chances of abuse. Supportive relationships with trained paraprofessionals during the extended perinatal period resulted in a significant change from negative to positive in high risk mothers' attitudes towards their infants.

This is in marked contrast to mothers who did not receive this kind of support. Parenting education was found to be helpful in dealing with specific cultural and socio-economic groups as well. Low-income mothers who completed a ten-month parenting curriculum, were more positive in their attitudes, more willing and able to negotiate social support for themselves in times of stress, and more hopeful about the future than were those of similar backgrounds who had not participated. And, the study documented that nonprofessional, caring people can make a difference.

Other smaller studies provide some findings about prevention research related to perinatal support and education programs and suggest that early contact between a parent and a new baby improved birthing procedures such as rooming in the hospital and home health visitors programs do have beneficial effects in reducing factors associated with abusive behavior. The findings from such studies are not consistent however. Some are hotly debated such as findings related to bonding and attachment, and they do not provide "proof" that child abuse will be prevented. Numerous studies have looked at parenting education programs; while generally poorly designed, the studies do suggest that parenting education programs can be helpful for parents and children alike. And finally, a few studies have looked at the impact of child-oriented prevention programs; these rudimentary program evaluations show that programs which provide information to children about sexual abuse, for example, and how to protect themselves from it, are in fact effective in helping children reach out for help to avoid abuse.

These and several other small federally funded research efforts are contributing to our knowledge of prevention; as too have some state and local projects. In Illinois for example the Ounce of Prevention Demonstration Program is currently under scrutiny by university researchers. And several dozen community prevention programs are known to be conducting their own evaluations to assess the effectiveness of their programs. (Most of these efforts have been analysed and cataloged in two attached documents, An Approach to Preventing Child Abuse by Anne Cohn, attachment A, and "What Have We Learned About Preventing Child Abuse?" by Ellen Gray, attachment B, or in forthcoming NCPCA working paper by Michael Wald and Ellen Gray entitled "What Do We Really Know From Research About Preventing Child Abuse."

In addition, we have just begun to see a proliferation of local child abuse prevention efforts which have resulted in extensive experience about the value or benefit to such programs. (Some of these are described in the attached "Innovative Approaches to Preventing Child Abuse"—attachment C). One common experience worth noting is that prevention programs based on visual or dramatic presentations or those which is some way use the media, have clear and visible effects. For example, the TV movie "Something About Amelia" resulted in thousands of people reaching out for help to eradicate the scars of sexual abuse.

What's the bottom line? Do we really know how to prevent child abuse. Most dedicated researchers would say that we do not have 'researched knowledge' about prevention; they would point to a very few studies, which provide defensible kernels of knowledge. But in settings outside the circle of disciplined researchers, most of us working in the child abuse area would say, "Yes, we know a lot about how to prevent child abuse. Our knowledge isn't perfect. Most of it comes from our experiences, and common sense. But we do know a lot about what causes abuse and about that kind of interventions or supports for families seem to alleviate or in some way impact those causes, thereby reducing the likeihood of abuse.

How can child abuse be prevented? Based on what we know, our best approach to prevention would be one that is multifaceted, which addresses the needs of parents, children and families at every phase of the family life cycle and which is community-based or otherwise adapted to the specific value, norms, mores and resources of a given neighborhood or community or population group.

We've learned that there are many ways in which community resources need to be harnessed to prevent child abuse. Because child abuse is a complex problem with numerous causes it is necessary to implement programs that will address multiple problems and needs and to coordinate these programs in a comprehensive, community-based prevention strategy. Based on what studies have shown about who is at risk and what causes abuse and with a concern for the child in the context of the family, the goals of a comprehensive approach to prevention should be to:

Increase future parents' knowledge of child development and the demands of parenting; Enhance parent-child bonding, emotional ties, and communication; Increase parents' skills in coping with the stresses of infant and child care; Increase parents' skills in coping with the stresses of caring for chidren with special needs; Increase parents' knowledge about home and child management; Reduce the burden of child care; Reduce family isolation and increase peer support; Increase access to social and health services, particularly crisis or emergency services, for all family members; Reduce the long-term consequences of poor parenting and break the cycle of abuse; and Increase children's abilities to protect themselves from abuse.

Based on what is known or believed to enhance an individual's ability to function in a healthy way within a family, program areas that contribute to a strategy for prevention can be identified. These program areas are:

Support programs for new parents;
Education for parents;
Early and regular child and family screening and treatment;
Child care opportunities;
Programs for abused children and young adults;
Life skills training for children and young adults;
Self-help groups and other neighborhood supports;
Family support services;
Support through the workplace; and
Public information and education on child abuse prevention.

These program areas begin with the prenatal period, furnishing prospective parents with information and skills related to child care and child development. They continue with services and support programs for parents of infants and young children, and include services for the child throughout the school years. The workplace is included as a site to provide support to families. And they are supplemented with communitywide education. Although a community may choose not to offer services in all program areas, as a group they respond to the needs of all family members. More descriptions of these program areas follow:

SUPPORT PROGRAMS FOR NEW PARENTS

The purpose of support programs for new parents, such as perinatal support programs, is to prepare individuals for the job of parenting. Such programs should include supports during both the pre- and postnatal periods. Prenatal programs can build on existing medical programs and educate about-to-be parents in child development, parent-child relationships, and adult relationships. Information on community resources available to new parents and to infants and children should be provided. In supplying information and in teaching skills for coping with the challenges of being a parent, special emphasis should be placed on developing techniques useful in communicating with the new baby. One focus of these services should be to develop group activities that form a social network among new parents, thereby creating peer relations and peer support. Although such programs should be available to all parents, special attention should be paid to first-time parents, teenage parents, and single parents.

Prenatal and postnatal medical care is clearly important, particularly since low-birth-weight babies and babies otherwise sick in infancy are at risk for being abused. Many prospective parents now participate in prenatal care programs that go beyond the medical needs of the pregnant mother and the growing fetus to include attention to the demands of parenting. All prenatal care programs should provide prospective parents with parenting education and other supports to ease the difficulties associated with having a new infant in the home. A program such as ABC: Any Baby Can (see attachment C) offers invaluable support to parents of children with special needs—in this case handicapped children.

Studies suggest that in families in which parent-child bonding is weak the child is at greater risk for abuse. Part of the function of perinatal support programs should, therefore, be to enhance parent-child bonding. Childbirth procedures involving both parents, rooming-in, and unlimited visiting privileges for parents with their infants are important. Minor changes in hospital procedures should facilitate opportunities for families to get to know their newest member, while enhancing the opportunities for early and effective parent-child bonding. Many hospitals offer prospective parents the opportunity to participate in programs that enhance the bonding process. All hospitals should offer such options. Programs such as the Parenting Linking Project or Caring Connection do a nice job of addressing these issues (see descriptions in attachment C).

EDUCATION FOR PARENTS

As a continuation of the prenatal program and as part of perinatal support programs, all new parents should have an opportunity to participate in a program to increase their skills in caring for a new baby. The program should be directed toward the creation of social networks, through new-parent groups or by pairing first-time parents with experienced parents, and toward the continuation of instruction in child care and child development.

Having a new infant in the home creates stress in any family. When, however, the infant requires extra or special care, stress can be greatly increased, putting the child at greater risk for abuse. To reduce the additional stresses created for parents by infants with special problems following birth—for example, premature babies or those with illnesses, abnormalities, or defects—a special educational support program should be available. The program should focus on group support from parents with similar children, and it should educate parents about the particular needs of their child and how to deal with those needs in a family environment. Every attempt should be made to furnish supports that minimize distortion of the parents' perception of their new child. Separating newborns from their families to provide intensive care can require special adjustments for parents, and they should receive help that is sensitive to this unique stress.

Among the problems experienced by families with young children is isolation from and lack of knowledge about health and social services in the local community. Coupled with a lack of knowledge of how to detect and handle many childhood problems, this puts a family at risk for abuse. As an ongoing source of support and information for parents, educational support programs should include home visitor services that consist of periodic visits to the home following childbirth until the child begins school.

These visits should be made by a trained home health aide under the supervision of medical professionals. The aide should provide information and advice to parents on child care, nutrition, and home management and should carry out routine health checkups on young children. In addition, the aide should refer parents to needed social and health services in the community. In some communities the services of the home visitor can be effectively rendered through a local well-baby program. The EPIC program in Buffalo, N.Y. (described in attachment C) is a good example of an effort to provide parenting education throughout the school system.

EARLY AND REGULAR CHILD AND FAMILY SCREENING AND TREATMENT

Because abusive behavior is cyclic, many health and developmental problems in childhood can lead to behavioral problems in adulthood, including abusive behavior. For this reason detecting and treating health and developmental problems early in life is important. Early childhood screening and treatment programs should be seen as a continuation of the preschool screening services, such as those offered by the home visitor. The purpose of such programs should be to detect problems children may be having, including abuse and neglect, and to ensure that these children receive the necessary healtlh, mental health, and other services that will best protect them from becoming abusive parents.

Screening and treatment programs exist throughout the United States in preschools and schools; they should be available to all children. All screening programs, however, need to be sensitive to the possibility that a child may be inappropriately labeled, with long-term negative consequences.

CHILD CARE OPPORTUNITIES

The purpose of child care or day care programs is to furnish parents with regular or occasional out-of-home care for their children. While child care is a necessity in households in which all adults are employed, such services are also beneficial for parents who do not work outside the home but who find continuous child care responsibilities very stressful. Child care programs also provide opportunities for children to learn basic social skills. Head Start programs in particular provide a rich mix of child care and child development services.

PROGRAMS FOR ABUSED CHILDREN

It has been argued that prevention of abuse is in part tied to providing therapeutic treatment to children or young people who have been abused or neglected. To minimize the long-term effects of abuse, age-appropriate treatment services should be available to all maltreated children.

Treatment programs for abused children should include a thorough diagnosis of physical and developmental (social, psychological, and emotional) problems. Comprehensive therapeutic services should be offered to alleviate identified problems. Assistance should be rendered on the basis of an individual child's needs and should include individual and group services as well as an enriched day care program. The newly formed P.A. children's groups are an excellent example of this approach (see attachment A).

LIFE SKILLS TRAINING FOR CHILDREN AND YOUNG ADULTS

The purposes of life skills training are first to equip children, adolescents, and young adults with interpersonal skills and knowledge that are valuable in adulthood, especially in the parenting role; and second, to provide children with skills to help them protect themselves from being abused. Knowledge and skills can be imparted in a variety of ways; irrespective of the specific techniques, educational classes or supports should be provided through the school system and through adult education centers.

Skill and knowledge building should be stressed in areas of child development, family and life management, self-development, self-actualization, and methods of seeking help. For adolescents in particular, education in sexuality, pregnancy prevention, and issues related to parenting should be provided. Programs in this area have proliferated in the past 2 years. Two nice examples are: the play 'Bubbylonian Encounter', a sexual abuse prevention play for elementary school children which teaches them how to protect themselves from child abuse and 'Little Kids Bug Me,' a curriculum for young children which helps them at an early age being to develop parenting skills (both are described in attachment C).

SELF-HELP GROUPS AND OTHER NEIGHBORHOOD SUPPORTS

Social isolation, not having anyone to turn to in times of need, plagues most families who are at high risk for abuse and neglect. The purpose of self-help groups is to reduce the isolation experienced by many parents through the development of peer support systems.

Beginning with social networks created through parent groups in the prenatal and perinatal programs, a variety of opportunities should be offfered for parents to participate in group activities or to establish social contacts. Examples include parent groups stemming from local child care programs Foster Grandparent Programs, Parents Anonymous, and comparable problem-oriented self-help or support groups. The mutual aid programs should also focus on the development or strengthening of neighborhood-based natural helping networks. Self-help groups for victims of abuse appear to be particularly promising (see description of FACES in attachment C).

FAMILY SUPPORT SERVICES

Lacking anywhere to turn in time of crisis puts families at significantly greater risk for abuse or neglect. To provide immediate asistance to parents in times of stress, crisis care programs should be available on a 24-hour basis and should include the following services: telephone hot line, crisis caretakers, crisis baby-sitters, crisis nurseries, and crisis counseling. Through these programs, parents facing immediate problems could receive immediate support to alleviate the stresses of a particular situation. Help should be available over the phone or through in-person counseling.

The program should also offer parents the options of having someone come into their homes on a temporary basis to assist with child and home care or of taking the child to a crisis nursery. Because crisis care is temporary and short-term, such programs should be equipped to refer parents to long-term services as needed.

SUPPORT THROUGH THE WORKPLACE

Families can be strengthened (and weakened) by what happens at the workplace; this can in turn affect the presence of child abuse in the home. A variety of family support and child care opportunities can be, and are, offered in the work setting or through the work setting. So, too, flexible working hours, cafeteria fringe benefits, shared jobs and other innovative work policies can contribute to stronger families. (The attached paper, Strengthening Families Through the Workplace by Peter Coolsen, discusses this in depth, Attachment D.)

PUBLIC INFORMATION AND EDUCATION ON CHILD ABUSE PREVENTION

Public awareness compaigns have two complementary purposes. The first is to bring parents the message that being a parent is not easy, that all parents experience stress in the parenting role, and that it is all right to reach out for help. The second purpose is to provide parents with information about where to turn for help, particularly how to get in touch with local crisis care services.

Awareness on the part of professionals and volunteers is also essential to the effectiveness of a community's prevention programs. It is particularly important that those who come into contact with families, such as physicians and teachers, receive training in the dynamics of child abuse and information on the availability of prevention programs in the community. The NCPCA's newest media campaign is an excellent example of how the media can be a tool for preventing abuse. With the tag line "Take Time Out. Don't Take It Out on Your Kid" the campaign offers tips on parenting through TV and radio spots, print ads and transit advertising.

CONCLUSION

Can we afford to let the paucity of our knowledge base stand in the way of efforts to stop the flow of water, and stop child abuse? I think not and I hope not. We unwincingly spend well over $2 billion a year responding to the problem after the fact—without having a solid base for knowing how to treat the problem. Surely, we should be able to master a comparable effort on the prevention end. And, we must. Child abuse is on the rise in this country. It's growth will not be slowed with treatment programs.

A constant concern, of course, is do we have to take scarce dollars away from treatment in order to fund prevention. The answer is no, not always. One approach to funding child abuse prevention that is catching on rapidly is the Children's Trust Fund. In an era of diminishing governmental budgets for social services, this concept has emerged as an imaginative funding solution for abuse prevention programs. Beginning in 1980, states across the country have established these public funds to support preventive services. To date, 15 state Trust funds have been established. Lawmakers in other states are considering similar legislation.

Revenues to build the Children's Trust Funds are generated by surcharges on marriage licenses, birth certificates, or divorce decrees, or by specially designated refunds on the state income tax. Grants from the fund go to preventive programs for child and family abuse, and distribution of the grants is supervised by an advisory group of individuals with a demonstrated interest in preventing child abuse.

Prevention is the central focus of the Children's Trust Fund concept. The idea was first conceived by Ray E. Helfer, M.D., a pediatrician widely recongized for his pioneer work in the field of child abuse.

The NCPCA is making public its commitment to reduce the amount of child abuse nationwide by 20% by the end of the decade. We do not expect to be able to precisely measure the accomplishment of this goal. But we do believe that with a continuing proliferation at a wide variety of community based prevention programs which support new parents, educate children in how to protect themselves form abuse and assist those who have been victims of abuse, our goal can be met.

Materials referred to as attachments A, C, and D in the preceding testimony are the following published materials and working paper:

Cohn, A. H. *An Approach to Preventing Child Abuse,* National Committee for the Prevention of Child Abuse, 1983.

Carlson, P. *Strengthening Families Through the Workplace.* National Committee for the Prevention of Child Abuse, 1983.

Innovative Approachs to Preventing Child Abuse: Volunteers in Action. Working Paper 015, National Committee for the Prevention of Child Abuse.

Mr. **Lehman**. Thank you very much for your testimony.

I have several questions I would like to submit to you for the record and just a couple of questions I would like to ask you personally. One is we have spent a lot of time on this subcommittee talking about preventive strategies on prenatal and neonatal low rate babies and those kinds of problems. I just wonder, if you have any data on the correlation between those children with poor prenatal and poor neonatal care as it relates to that child's possibility of being abused at a later time?

In other words, are the same forces at work among the parents that are neglectful both before and right after the child is born? Can you almost anticipate that same child may be more likely to be abused and neglected later on?

Ms. COHN. I would be delighted to submit for the record some research that looks at this. I think there are two different aspects to the issue. One is that parents who receive no or poor prenatal care are people who are not necessarily getting support from the system, they are not connected up with other people, they are not getting help in understanding what the demands of the new child are going to be, so therefore, they are at somewhat greater risk.

In addition, children who are low birth rate or otherwise sickly around the time of birth pose that much greater stress for their parents, because they are much more difficult to care for.

Mr. LEHMAN. The other question, demographically, in the rural areas, is there any difference in child abuse there or in the more metropolitan high density areas? I once read that there was more incest perhaps in rural families because boys didn't have anybody but the family to relate to within 5 miles sometimes, or girls. I wonder whether there are any demographic data on the instances of child abuse, child negligence, in metropolitan areas versus those in rural areas, and if you want, you can submit that for the record, because I think it might give us—or you can make a statement, something to go in about resolving this problem.

Ms. COHN. As best we can tell, the instances of child abuse do not vary according to rural or urban settings, and I think that whole myth about sexual abuse occurring more in rural settings has been exploded in the last couple of months. Just look at the letters we received after "Something About Amelia," they are from every kind of community across the country. I think as our knowledge base grows, we have a better sense of this and I will certainly submit information for the record.

Mr. LEHMAN. You mentioned something about children that had health problems, physical disabilities and so forth, that they were abused more than otherwise. I have a good friend that is a physical therapist, and he says—he makes house calls, and he told me one of his biggest problems in his physical therapy practice is the physical abuse that his patients receive from other members of their families. Would that be a fairly acceptable statement based on your experience?

Do you think that afflicted children have more abuse than nonafflicted children?

Ms. COHN. There is evidence that suggests that, yes.

Mr. LEHMAN. And the last question—I don't want to have to reinvent the wheel, and there are other countries that I am sure have the same problem.

When I was on the Education Committee for the sheltered workshops, I went to Vienna and Frankfurt to see how they were handling it, which was far superior to the way we are handling it as far as dealing with the problem of retarded children. I saw people doing things we haven't come close to doing.

In what other societies, even Third World or Japan or Western Europe or whatever, even Communist countries, are there programs either sponsored by the government or in the private or nonprofit section that we can look at or study that may give us some help in dealing with the same problems in this country. Many of those societies have been much more stable than ours and have been dealing with these same kinds of problems at some level over centuries. So I don't know if we ever have funds on this committee to go someplace to study this problem, but maybe we could learn something from other countries and from other societies and from other cultures.

Ms. COHN. Most of the European nations have flagged child abuse as a signficant problem and have begun to do things in that area and in many cases their activities are ahead of ours, and in some instances behind. Great Britian has some excellent treatment and preventive approaches to child abuse. In the Scandanavian countries you see some wonderful examples of home health visitor programs and providing child care opportunities for all parents that seem to be helpful. However, I think the key really lies more in the values and the mores and the social fabric, if you will, of a nation. In China it is very rare to see children who are abused.

Mr. LEHMAN. Where?

Ms. COHN. In China it is very rare to see child abuse, and I think it has to do with the values that that country and those people have about their children. They value their children more, perhaps, than anything else, and the notion of hitting a child, the notion of somehow abusing a child is so abhorrent to them that it doesn't happen very often.

Mr. LEHMAN. They have a reference in the old Chinese culture through the generations.

Ms. COHN. So, I think there is a lot to learn from some nations because of the values that those people have about children, and there is a lot to learn from some other countries that have our same problems and similar values and trying too to combat the problem.

Mr. LEHMAN. If we had $50,000 to $100,000 to take members of this committee on a trip someplace, not a junket, but a real trip, to study what we could learn on child abuse from other countries, where would you send us?

Ms. COHN. I would send you to Montreal next September because there is going to be an international congress on child abuse and neglect and there will be people from nations all over the world, from both developed and undeveloped countries talking about what it is that is going on in their country. So with one short trip you could cover a lot of nations at one time.

Mr. LEHMAN. I think that would be good.

What is Montreal itself doing?

Ms. COHN. The Canadians have a variety of interesting programs going on.

Mr. **Lehman**. Better than ours? Is the French Canadian different than the British Canadian?

Ms. **Cohn**. I don't know that I can really give you a good sense of——

Mr. **Lehman**. I don't like conferences.

I like to go right to see the school or the shelter workshop, or the child abuse center, or the place where there are shelters for abused mothers and children in operation. I can learn more from that than I can from somebody reading a paper at a conference. I can understand. Other than that, where would you go? I want to see a program working.

Ms. **Cohn**. I am sort of biased. I would love to design a program for you that keeps you right in this country because I think there is phenominal things going on in New Jersey and New York and across the country.

Mr. **Lehman**. I have no problems with that.

Ms. **Cohn**. But if you really want to get a sense of how a society, a whole society really cares for its children, so there is no child abuse, I think I would brush up on my Chinese and go to China.

Mr. **Lehman**. That might not be a bad idea. OK, I yield to Mr. Bliley.

Mr. **Bliley**. Thank you, Mr. Chairman.

How many chapters of NCPCA are there in the United States?

Ms. **Cohn**. We now have 46 chapters. Most of them are statewide and some of them cover a region of a State.

Mr. **Bliley**. Are there any overseas?

Ms. **Cohn**. We have no formal activities outside of the United States.

Mr. **Bliley**. How many volunteers are involved?

Ms. **Cohn**. It is difficult to count. We know it represents many thousands of volunteers. A given chapter may be working with several hundred people through its public education activities or its parenting classes and so on, so we don't have an exact number, but we know at least the membership of our chapters collectively is over 4,000.

Mr. **Bliley**. What percentage of child sexual abuse takes place between family members?

Ms. **Cohn**. Most.

Mr. **Bliley**. Of these, in what percentage of cases is the perpetrator a stepfather or someone not naturally related to the child?

Ms. **Cohn**. I don't think that I can give you a figure that would necessarily be a true figure. It is a fairly high percent, but whether it be the stepfather, the father or an uncle, we know that those three figures—a brother is the fourth—are the key figures in most cases of sexual abuse.

Mr. **Bliley**. How much of child abuse do you consider to be as a result of lack of knowledge on the part of parents?

Ms. **Cohn**. I think all child abuse includes some lack of knowledge or understanding on the part of parents, but there are all kinds of other factors that are also relevant.

Mr. **Bliley**. Would you say it is more a lack of knowledge or more a result of a lack of emotional support?

Ms. **Cohn**. I think both are equally important as are issues of stress that happens to be going on in a person's family at that time. It may be unemployment, it may be financial difficulties, it may be alcoholism and drug abuse, it may be other things.

Mr. **Bliley**. What has your experience been—I noted in your brochure that you are involved with the advertising council in New York and also an ad agency, Campbell Ewald.

Ms. **Cohn**. Yes, sir.

Mr. **Bliley**. What has been your experience with the acceptance of this by media across the country and the willingness to air these public service announcements?

Ms. **Cohn**. We have been overwhelmed with the reaction the media has had. In fact, last year the child abuse campaign sponsored by the advertising council ranked third of all of their public service campaigns.

You know, they do Smokey the Bear and a whole host of other really well known and well utilized campaigns.

The value of our campaign last year in terms of donated dollars was about $48 million. That is a very powerful advertising campaign and it reflects the commitment, I believe, on the part of the media to do something about this problem.

Mr. **Bliley**. And the results after you did this, the response, the call-ins, the reaction in the community?

Ms. **Cohn**. I think our best measure of the response to the campaign has to do with the public polls that we have been able to do and have also had Louis Harris & Associates do, that give us a measure of how aware the public is now of the problem. Clearly there are a lot of things that have contributed to the public's awareness. States and local groups have done some of their own public awareness campaigns and there has been a lot in the press and so on. But it is clear that since we started this continuous national campaign in 1976, awareness on the part of the public has gone from maybe 1 out of every 10 adults recognizing something called the battered child syndrome and over 90 percent of the adult population not only being aware of the problem, but understanding the different types of abuse and neglect, the connection to unemployment and economic stress as well as various forms of criminal or delinquent behavior.

Mr. **Bliley**. Thank you.

Mr. **Lehman**. Before we go to Mr. Anthony, Mr. Miller, chairman of the select committee, has a statement for the record and without objection, it will be inserted in the proper place in the record.

Mr. **Anthony**. Thank you, Mr. Chairman.

Ms. Cohn, you made a statement which I think we probably all agree with. It is an ideal we will never reach but should always strive for.

You said the solution was the moral fabric of a nation. We say the United States is the most moralistic society in the world. We talk about our freedom of speech, our freedom of movement, and all the great things we have, yet we know we are spending billions of dollars, as you noted in your testimony, after the fact of child abuse.

I spent 10 years of my life dealing with child abuse cases similiar to the ones you described, before I came to Congress. One case that I recall concerns a gentleman who went to Vietnam and came back a total nervous wreck. One of the neighbors brought his child into my office one day—I was the local prosecuting attorney—the child had what appeared to be cigarette burns on his right side, under his tongue, between the index finger on both hands, and then likewise between the big toe and the next toe.

I subpoenaed him and I asked him, "How did that occur?" He said, that he was burning trash and it was all an accident.

It was obvious he was a gentleman under a great deal of stress from a moral commitment that his country had asked him to live up to; for example, serving in a war he probably didn't want to fight in.

I guess my real question, knowing that the total solution is not going to be the moral fabric of our country, is where does Federal involvement, State involvement, church involvement, and private enterprise involvement all fit in?

We are a nonlegislative committee, yet we can make reports to legislative committees about whether or not there needs to be more Federal involvement.

You have mentioned several areas where you say prevention can be identified. Quickly looking over them, they all appear to require some money and/or some effort. Could you quickly summarize where you think the Federal Government should be involved versus involvement from other sources?

Ms. COHN. Let me mention one. I think there is a very clear role for the Federal Government in encouraging States to do something that would create the dollars that are necessary to accomplish some of these prevention goals. There is a piece of legislation that was introduced in Kansas a few years ago, and passed, and since been passed in 13 other States called the "children's trust fund." In about half of the States where that trust fund has passed, the law actually adds some kind of surcharge or tax onto marriage licenses or birth certificates—$6 in some States, $10 in others. In the other half of the States, instead of a special surcharge, citizens actually have an opportunity on their income tax refund form to check off a box that will take $10 out of their refund or $5 and put it into a special children's trust fund.

Now, in these 14 States those dollars are not a line item in the State's budget but rather a special pot of money that is developed through these special taxes or checkoffs, and those dollars are used exclusively for local child abuse prevention or family violence prevention activities. It has been a marvelous opportunity for those few States to develop a new source of dollars without competing or taking away dollars from the treatment end, and to provide opportunities for local groups to actually begin to develop prevention activities.

So I think one important role for the Federal Government and for your committee to play might be to develop ways to encourage States across the country to develop similar legislation.

Mr. ANTHONY. Then you see the Federal role as developing national policy; that is, more of a national spokesman rather than getting involved with more legislation, or appropriating more dollars to the States through block grants and/or appropriated programs?

Ms. COHN. I am certainly not a person who is opposed to some increased Federal support in these areas, but my belief is that at this moment that may be secondary to actually encouraging things to happen at the State and local level. There is a public out there that is so concerned about this problem and so anxious to do something, they need to know what to do.

There is a tremendous amount that can be accomplished through volunteer efforts. When I think about Parents Anonymous and what they have been able to accomplish, it gives a wonderful sense of just how true that is. With the few dollars and with the right people involved, and incentives for them to be involved, a lot can be accomplished.

It is my feeling that right now we need to take advantage of that concern on the part of the general public, the concern in communities to do something, and make sure that at least those minimal dollars are available to those people so they can get started.

Mr. ANTHONY. Before I leave you, let me ask you to do a little extra work on one of my pet peeves—the foster parent program. Unfortunately when we had a suspected child abuse case in my jurisdiction—it was a five-county area that I represented in southern Arkansas—we would go to the support areas. Many times that entailed going to the juvenile court and trying to put the child into some temporary safe custody, which was a foster parent type situation.

I must admit I was not totally satisfied with the outcome in many of the foster parent cases, where you had termination of natural parents' rights and sought adoptive procedures. Is there anything that your association or group could do to advise us on that? From 10 years of experience I can say that there is a breakdown in this system and we need more State and local coordination. Thank you.

Ms. COHN. Thank you. I concur.

Mr. LEHMAN. Mr. Bliley.

Mr. BLILEY. No additional questions.

Mr. LEHMAN. The only question—I have one other question—one is that you mentioned these trust fund moneys. There is a shortfall in the funds available, I assume, to provide for the needs that you see. Is there a way that we could recommend to one of the other committees, some kind of a Federal assistance to the States as a form of leverage to increase these trust funds, that you see as a badly needed asset to deal with these problems?

Ms. COHN. I think that is the very kind of incentive that a lot of States will need to get that kind of legislation going. I think that is an excellent idea.

Mr. LEHMAN. I have another question for the record for you here, and we are not going to China because I think there are so many other factors involved in that culture, but I was trying to think of someplace either in this country or in Western Europe that had similar cultures that we could adjust to, not the culture but the way they deal with the problem. And of all the Western European cities I have been to, I find that Glasgow, Scotland seems to spend more and do more for their children in the form of health, education, and welfare than any city that I have ever been to, especially in relation to its economic problems. And if you could look into that and see how it is either in this country or in Western Europe, because it is hard for us to adjust to how they are dealing with children in China, how they might be dealing with children in Dakar or even in South America. But we should be able to see how programs are working in Scotland or programs are working in Rotterdam or some place like this. I think we have a lot to learn without reinventing the wheel.

Thank you very much.

Ms. **Cohn**. Thank you.

Mr. **Lehman**. We have panel No. 1.

Before we do bring this panel forward, Ms. Fae Deaton, the social worker, is accompanied by a parent from Virginia, that for reasons of privacy, will have to testify without being recognized. So until he is able to come in and be behind the screen, I have no choice but to respect his wish and ask that the room be cleared for just a couple of minutes until we can reestablish this person behind the screen. So, give me the courtesy and we will have you right back in here.

[Recess.]

Mr. **Lehman**. The first people that will be testifying on the panel will be Leonard Lieber and Cheri Stevens. Are you here?

Ms. **Stevens**. Leonard Lieber is here.

Mr. **Lehman**. Ms. Stevens. I am glad to have the social workers onboard. I think the social workers are perhaps the first ones to identify this problem of any of the professionals that I have had experience with. We would like to hear your statement. It is essential that you summarize it.

Without objection, those statements in their entirety will be inserted in the record, so we will take the two of you and then we will do questions and answers before we move forward to the next witness, so go ahead and summarize your statement and either one of you can move first.

STATEMENT OF LEONARD LIEBER, EXECUTIVE DIRECTOR, PARENTS ANONYMOUS, SAN JOSE, CA

Mr. **Lieber**. Thank you, Mr. Chairman. We will be as economical with our time here as we are with our program.

We really appreciate the opportunity of being with you today to make a few comments about things which we see around the United States and beyond where we have our program. Although I officially represent the Parents Anonymous national organization for parents and children experiencing child abuse, my colleagues from California and Virginia will direct their comments about the PA program and its impact on families at risk of child abuse.

Mr. **Lieber**. My name is Leonard Lieber. I am the executive director of the National Parents Anonymous organization. I was involved with the development of the program as it began in southern California some 15 years ago.

My brief comments are more general and concern the human services field. I think I can make some comments on that issue because I believe I was one of the first protective services workers in the United States when Los Angeles County received some Federal funding in 1965–66 for protective services and we each had—five of us workers—each had a population area of 1 million people to serve as a protective services worker, and I must say, we probably had more fun in our work then because we knew less and people didn't expect as much from us then——

Mr. **Lehman**. You said you had more fun or funds?

Mr. **Lieber**. Fun. In a sense, we have learned how to have fun in working with child abuse. There is a way of doing that, and, not being facetious, it is a matter of feeling good about doing things that are very productive for people.

You, as a factfinding committee, have heard much testimony in the past several months about the decline in services to America's children, in great part because of cutbacks in real dollars from public funds to support certain basic children's needs. They include minimal nutrition, housing, freedom of abuse and neglect and the like.

These concerns are of merit and must be addressed for money buys coordination of services and certain crucial life supporting items, if nothing else. Yet, it is imperative for everyone to accept the argument that human misery does not go away just because you throw money at it. Many of us learned this lesson in the Great Society era of the 1960's when billions of dollars seemingly bought little for those for whom the money was originally intended.

I may sound extremely hardlined and conservative. Perhaps those are some of my Indiana roots showing. However, I have spent most of my life in California which has helped put some creativity into the pragmatism, that I learned early on in my first 12 years.

What people cannot purchase with someone else's money is pride and self-worth unless they sense some control over their own lives. We have learned much in efforts to establish a self-help program for persons with child abuse problems. Our activities began in 1970 in southern California. Many of the people with whom we have worked nationwide have received social services from heavily funded public agencies and the trained staff within. Yet, the turnaround in these families' lives came when they used the support and guidance of each other and of volunteers—professionals and lay persons alike—in a self-help setting in which virtually no money changed hands. Our program now involve 8,000 such volunteers who are doing laying on of hands in a very emotional way with each other.

As an example, we quote the study of 11 federally funded child abuse and neglect projects, completed in the late 1970's by Berkeley Planning Associates:

> We found that parents who participated in Parents Anonymous, irrespective of whatever other services they received, were significantly more likely to have their problems resolved than clients who did not participate in this service.

We have heard from human service personnel throughout the United States and beyond who utilize self-help programs for everything from child abuse treatment and prevention to mutual support for widows, open heart surgery patients and parents of children with terminal illnesses. They find it possible to function better on the job because they have this access to auxiliary services.

By augmenting the services they offer to self-help programs, the cost effectiveness within our own case load increases, because they are freed up to serve additional persons referred from the community.

Recent reports by the National Institute of Mental Health, the National Center on Child Abuse and Neglect, Leonard Borman and his associates of the Self-Help Center in Evanston, IL, Frank Reissman at the Self-Help Clearing House in New York and staff at the National Clearinghouse on Family Violence within the Canadian Government, all point to the unquestioned value of self-help for a myriad of human problems.

It seems to a number of us that if more money is being requested by child serving agencies, a requirement be mandated that permanent plans be formulated and carried out to build in self-help programs within these settings. And I am not talking about expensive, one time only demonstration projects that disappear when the money goes away. I am talking about establishing an agency philosophy and policy which literally gives its consumer recipients the responsibility and freedom to help themselves, apart from grants, stipends or the like.

I know that getting people to change, especially professionals, is not easy. Yet we owe America's taxpayers the best return on their dollars. We at Parents Anonymous have received public moneys for some time and pride ourselves on trying to find the most cost effective means to empower people to improve their living circumstances, utilizing the power of professional expertise, volunteerism and self-help, in the process. For every dollar in cash we have received over the past decade, we have been able to leverage $10 in donated time and service.

I would have to mention that our children in the treatment program began to receive assistance 2 years ago with help from the Federal Government. We have leveraged that small amount of money into 40 communities where the program is operating. We have at this moment over 1,000 kids in the program. It is running about $80 per child per service per year. This is a matter of getting people involved and doing something for, out of a labor of love, not just because they are getting paid to do it.

We challenge others to do the same or at least be more willing to help develop and support a national policy on self-help in this country, particularly in the area of children's services, which will probably never have the kind of funding base which it so necessarily deserves.

As you all know, H.R. 1904 recently passed by an overwhelming majority. This legislation calls for continued support of the National Center on Child Abuse and Neglect and other selected family violence efforts. Amended language also gave support for self-help programs.

It must be pointed out to you today that funding for the Parents Anonymous National Program, the most successful and visible single child abuse program ever funded by the Federal Government, will lose its support from Washington in a year. H.R. 1904 did not specify ongoing support for Parents Anonymous.

To date, we have received the endorsement of four White House administrations, many Members of past and present Congresses, Time, Newsweek, U.S. News & World Report magazines, "60 Minutes," ABC's "Nightline," and the American public.

In the spirit of Yankee pragmatism, wise investment planning and a sense of fair play, we ask your assistance in allowing us to continue what we set out to do 15 years ago—give a child abusing family the tools with which to heal itself.

Now it is my pleasure to introduce you to a very special person from our program, Cheri Stevens, who is a Parents Anonymous member and coordinator for the PA Parents and Children's Treatment Program in Santa Clara County, CA.

[Prepared statement of Leonard Lieber follows:]

PREPARED STATEMENT OF LEONARD LIEBER, LCSW, CO-FOUNDER, EXECUTIVE DIRECTOR, PARENTS ANONYMOUS, TORRANCE, CA

Thank you for the opportunity to express our ideas and views today.

Although I officially represent the Parents Anonymous national organization for parents and children experiencing child abuse, my colleagues from California and Virginia will direct their comments about the PA program and its impact on families at risk of child abuse.

My brief comments are more general and concern the human services field. They are based upon by observation as someone who has had a personal experience of working in the public and private sectors during the past 20 years.

You, as a fact-finding committee, have heard much testimony in the past several months about the decline in services to America's children, in great part because of cutbacks in real dollars from public funds to support certain basic children's needs. They include minimal nutrition, housing, freedom from abuse and neglect and the like.

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We have learned much in our efforts to establish a self-help program for persons with child abuse problems. Our activities began in 1970 in Southern California. Many of the people with whom we have worked nationwide have received social services from heavily funded public agencies and the trained staff within.

Yet the turn-around in many of these families' lives came when they used the support and guidance of each other and of volunteers—professionals and lay persons alike—in a self-help setting in which virtually no money changed hands. As an example, we quote the study of eleven federally funded child abuse and neglect projects, completed in the late 1970's by Berkeley Planning Associates.

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To date, we have received the endorsement of four White House administrations, many members of past and present Congresses, Time, Newsweek and U.S. News and World Report Magazines, "60 Minutes", ABC's "Nightline" and the American public.

In the spirit of Yankee pragmatism, wise investment planning and a sense of fair play, we ask your assistance in allowing us to continue what we set out to do fifteen years ago—give a child abusing family the tools with which to heal itself.

I thank you for your time and for your thoughtful concern.

Now, it is my pleasure to introduce you to Cheri Stevens, Parents Anonymous member and coordinator for the Parents Anonymous Parent's and Children's Treatment Program in Santa Clara County, California.

STATEMENT OF CHERI STEVENS, NORTHERN CALIFORNIA COORDINATOR FOR PARENTS ANONYMOUS AND THE CHILDREN'S TREATMENT COORDINATOR, SANTA CLARA COUNTY, CA

Ms. STEVENS. Thank you.

Thank you, it is indeed a pleasure for me to be here with you today. I am a bit nervous. It is the first time I have done this.

I am Cheri Stevens, and I am the northern California coordinator for Parents Anonymous and the children's treatment coordinator in Santa Clara County, CA.

We have been very successful in our county with Parents Anonymous. We have many volunteers who have donated their time, services, and support to help abusive families in Santa Clara County.

What I would like to talk to you about is how does a parent get involved, what is the process, and what happens after it is all over? We have a parent in our group who wanted her story told. This is an excellent opportunity to let you know how a parent starts out being abusive.

This woman adopted 2 children 6 years ago. The night that she came home with these two children she was abusing her youngest daughter who at that time was 2 years old. The abuse continued for many months. When she went to her family's pediatrician to tell him that sometimes she spanked her kids hard enough to leave marks on them he looked at her and he said, "Hey, don't worry about it. A lot of moms spank their kids. It is part of their growing up."

When she spoke to her husband about it, when he saw the bruises, the marks, the tears, his response to her was, "Don't worry, dear. Tomorrow will be a better day."

Tomorrow did not get better. It got a lot worse. When she tried to speak to her own mother about it, her mother's excuse to her was, "If you had been able to bear your own children, you would not be abusing these children."

One night this mom had a particularly rough, abusive time with her oldest daughter. She slapped her repeatedly across the face, causing bruise marks, and at one point she threw her across the room. The child hit her head. She passed out. She came to with the mother standing over her screaming at her to get up, wanting desperately for this child not to be hurt but still very, very angry that this child would dare to pass out.

That night when the woman's husband came home he looked at his daughter, asked her what happened, she glanced at her mom, looked back at her dad and said, "I was playing in my room and I tripped and fell on my toys. That is how I hurt myself."

That happened in mid-November of 1978. For the next 6 weeks that mother did not lay one hand on either one of her children. She was deathly afraid of what might happen. She saw a program one night on television, it was on a public television station. It was titled "Raised in Anger." It was narrated by Ed Asner. It was an hour-long, four segmented program about child abuse. In that program that mom saw herself in each one of the segments including the last one where a father slapped his 7-month-old son across the face and killed him because his ring hit the baby in the temple of his head. That mom realized at that point just how close she came to killing her own daughter.

The following day she got in touch with the Parental Stress Hotline in San Jose, CA, who put her in touch with Parents Anonymous. The following night that mom got started in a group. Her husband did not want her to go. The adoption was not finalized. He was afraid someone would find out and take these children. This mom wanted her kids taken from her, but yet she did not want to give up being a mom, either.

As this mom continued in the Parents Anonymous program, she had to examine where she had been as a child, what was her life like growing up, what had happened to her, what events led up to her becoming an abusive parent. This mom finally had to admit that her parents had been abusive. She had been physically, verbally, and emotionally abused most of her growing up time. She had also been sexually molested by her father and by two uncles who had both tried to coerce her into incestuous relationships. At 23 years of age she was raped, and when she told her mother about it the following day, her mother said, "Just put it out of your mind. Nobody will believe that that is what really happened."

She went through two marriages where there was a great deal of spousal abuse in both of them. At one point she almost lost her own life. When she married again for the third time she thought that this time this is going to be right, I have chosen the right person. And instead she chose a man who was emotionally abusive.

This mom had to finally come to grips with all of this. It was difficult to do. It was difficult to look back over the past. She had a lot of people in the PA program who were supportive, who were there at any hour of the day or night so that she could call them when those feelings of rage got to be at a point that was overwhelming, where she was afraid she would hurt her children.

That mom has since gone on to volunteer a great deal of time to Parents Anonymous. She became a chairperson of her local chapter. She operated a 24-hour hotline. She has been on radio and television. She does sensitivity training with the San Jose Police Department, which has a force of over 800 uniformed officers. She worked with the juvenile and adult court systems.

Throughout all of this this mom has been growing and learning, and her children are very safe and protected now. Her children are now 8 and 10 years of age. If this mom did not have Parents Anonymous to turn to 6 years ago, her oldest daughter would be dead. That is a fact. That mom would be in jail or worse, she would have ended up committing suicide herself. Instead that mom has been given the opportunity to have her story told because she did get help, because there were people there. That mom is very proud to say that that mom is me and that I am here. I knew that my day had finally come when my oldest daughter, a year-and-a-half after I started in the group, came up to me one night as I was running around getting ready for group. Jennie asked, "Mom, you going to Parents Anonymous tonight?"

I said, "Yes, I am."

She said, "Do you have to go for yourself?"

I looked at this child whom I had almost killed. And I turned the question back on her and asked her how she felt about it. She answered "Well, Mom, you don't hit us anymore and you don't yell at us."

She then asked, "Do you go to PA now so you can help other parents so other kids don't get abused?"

And I said, "Yes, that is what I do."

And this little bitty girl came up to her 6-foot-tall mom and wrapped her arms around my legs and said, "Mom, I am really proud of you."

That is what it is all about. It is when our kids know that we have gotten better.

Thank you very much.

Mr. **Lehman**. I am not trying to psychoanalyze you, but it is the first time I have heard a professional use the word "mom" instead of "mother." I always think of "mom" as a term a child uses to address her own mother. Apparently you were so emotionally involved with this group of people and so familiar to them that you spoke of them as that mom. I have never heard exactly the term that way from just the standpoint. Do you use that word "mom" when you talk in your day-to-day life as a social worker instead of using the word "mother"?

Ms. **Stevens**. I certainly do, because even though we might be professionals (I am now in a paraprofessional capacity), I am still a mom but basically more than anything, I am a human being. I am a person. That is what we all are. Mr. Lehman, to clarify for the record my use of the word "Mom" in my previous testimony, I am that "Mom" that I was speaking of. I am not a police officer, social worker, probation officer, not a licensed therapist. I am considered a paraprofessional expert in the Child Abuse and Family Violence fields. However, my two daughters just call me Mom.

Mr. LEHMAN. Whatever you call them. The one question I have is in our area of south Florida, we have one council run by the Junior League in combination with the Conference of Jewish Women, we have others run by churches, various county organizations, local government organizations, and State health and human services. What role does Parents Anonymous play in bringing these nonprofit groups, church, and Government groups together in some form of community network to take care of these problems as they appear?

Ms. STEVENS. In Santa Clara County we have a council on child abuse. It is a county-run council that includes representatives from each of the different agencies to coordinate their efforts to provide services. We have a law that has been passed, SB-14, in California, that I think is going to be very good once it gets off and running, in that services must be provided for abusive parents.

Mr. LEHMAN. Does the Junior League, National Conference of Jewish Women, are you involved with them out in Santa Clara?

Ms. STEVENS. Yes, we are.

Mr. LEHMAN. You work with them as nonprofit as well as with the local and State agencies?

Ms. STEVENS. That is correct.

Mr. LEHMAN. How do you bring them together?

Ms. STEVENS. Very difficultly at times.

Mr. LEHMAN. Everybody wants their territory.

Ms. STEVENS. That is very true.

Mr. LEHMAN. Thank you very much.

Mr. Bliley.

Mr. BLILEY. Thank you.

Mr. Lieber, in your testimony you say Parents Anonymous is the most successful child abuse program ever funded by the Federal Government. Could you please give us more particulars about the success of Parents Anonymous? The numbers of families served and the cost of the program?

Mr. LIEBER. There have been about four separate research studies done on the PA program since we were federally funded in 1974. The first one had to do with the effectiveness of the overall program and some of the dynamics of the people who were involved so we could find out who we were serving. That program, that evaluation was done by an outside company in Tucson, AZ. It was found that within 2 to 3 weeks of joining Parents Anonymous groups back then most parents who had physical-abuse problems stopped physically abusing their children. It is not that difficult to stop physically abusing children if you have the right kind of support group. What is more difficult is emotional abuse and neglect of children, because you can be literally miles away from your kids and still abuse them emotionally and otherwise.

That study was followed by the Berkeley Planning Associates evaluation, which was earlier mentioned, on 11 federally funded child abuse programs which used different kind of methods to deal with child abuse—individual counseling, family counseling, self-help, whatever. Again referring to that study, it was found that perhaps the single most effective means of intervention with families was the use of peer group self-help, especially when it could be augmented by other kinds of things.

Half of our members are involved with other forms of services such as individual or family counseling. We certainly have always encouraged people to use whatever services can be of benefit to them, but the studies have indicated that when you are involved with someone who knows how you feel and who have gone through the experience that you have gone through, they have a very special therapeutic quality on you, and help you to feel not alone, not afraid, and capable for perhaps the first time in your life.

There was a study done by the Center for Governmental Research in Rochester, NY for the State of New York to determine the effect of confidentiality used by the Parents Anonymous system in that State. It was found that virtually half the people who became involved with the PA program in their study would have never surfaced in any type of public or private services because they were too unwilling and too afraid to own up to their problems in any setting except that of a self-help program. It was also found that the involvement which they had was beneficial in that their experience helped them to reduce or stop child abuse.

The most current evaluation going on with the PA program has to do with our currently funded children's treatment program where we have approximately 100 groups in 40 cities throughout the United States serving about a thousand children right now. The first information that came through, and I did bring some of it with me, basically spoke to what kinds of problem the kids were experiencing. What we are finding is that we have access perhaps to as much information about the problem of child abuse with children as anybody because our network is so large.

One of the most interesting statistics that we were able to pick up was that virtually half the teenagers who were involved in our program reported that they are alcoholic, which we had always sort of suspected. But it was really dramatic to see that come out. Some of the other information indicated that children as young as 2 and 3 and 4 were showing 5 and 6 and 7 and 8 different kinds of very, very serious problems, from mistrust of authority to being afraid of the dark.

The current evaluation that is going on has to do with the actual effectiveness of the various programs in which our kids are involved, whether they be teen mothers or whether they be infants, whether they be, as you will hear with our Virginia program, teenagers who are helping other abused children as paraprofessionals. So the evaluation is going on, showing that the program has made a positive effect, is very, very inexpensive, and is capable of leveraging private support as well as helping our State and local organizations obtain additional dollars that come through the Federal services.

Mr. BLILEY. Thank you very much. I have a couple other questions but I will submit them to you for the record.

And, Mr. Chairman, if it is in order, I would like to make a unanimous-consent request that that information that you have just mentioned be made a part of the record.

Mr. LEHMAN. Without objection.

Mr. **Bliley**. Ms. Stevens, in your opinion, what is the secret behind the success of Parents Anonymous?

Ms. **Stevens**. In my experience it is knowing that there are other people who have the same problem that you do. That you are not alone. That somebody has had a success in dealing with their abuse, of knowing that there are people you can call at any time, day or night, that will be there for you.

Mr. **Bliley**. In your opinion and from your experience, which would you say is the most damaging to children, physical abuse, which you can often see, or the emotional abuse from name-calling or neglect?

Ms. **Stevens**. In my opinion, short of killing a child through physical child abuse, verbal and emotional abuse are the worst kinds of abuses. Those you cannot see. Those you cannot put a picture up on a TV screen and sensationalize it. Those do not lead to any outside marks. It is all on the inside, and those are much more difficult to deal with.

Mr. **Bliley**. I thank you. I have a couple more questions, but like Mr. Lieber, I will give them to you and you can submit them for the record.

Thank you, Mr. Chairman.

[The information follows:]

Mr. **Bliley**. Could you please explain the importance of non-professionals and volunteer professionals to the success of Parents Anonymous?

Ms. **Stevens**. The importance of volunteers in making Parents Anonymous a success lies in the fact that neither professional nor non-professional volunteers are paid for their services. In this way, Parents Anonymous does not have to (nor have they ever) charged for services rendered to abusive parents. Our organization is based on voluntarism thereby cutting costs and overhead prevalent in other organizations. Volunteer professionals offer their "book learnin' ", which is very important, and nonprofessionals, such as former abusive parents, can offer their expertise in dealing with abusive families.

Mr. **Lehman**. Mr. Anthony.

Mr. **Anthony**. Thank you, Mr. Chairman.

Ms. Stevens, you indicated in your testimony very graphically and in a heart-rendering way about your daughter grabbing you by the leg. She obviously at that point had gained some confidence in you and apparently you had gained some confidence in yourself. I wonder if you would detail for the record what you consider to be some of the factors and circumstances that evolved to create the confidence in yourself which established that trust between you and your child.

Ms. **Stevens**. I think one of my first recollections that I felt I was getting better was when I got very angry one evening, this was, oh, maybe a month after I had started in the Parents Anonymous program. Being very angry, I did not hit my daughter. Instead I walked out of the room, and I slammed my fist against a door. It hurt like anything. I realized that I could have very well stood there and taken out my rage on this child. But when I hit that door I realized how hard I was hitting because I hurt myself. And I started laughing. I was so proud of myself. When my ex-husband came home from work that night I told him. I did not hit her. I hit the door. He walked over to see if I had damaged the door. And that was probably about the middle of the end. I cannot say it was the beginning of the end of our marriage, but about the middle of it.

I knew that when I could sit on my hands and keep myself from moving forward to my children to do something to take out my anger, that I had gotten better. I knew that when I could keep my mouth shut, and that was the hardest part to stop, the verbal abuse, learning how to zip your lip is a lot harder than learning how to sit on your hands and not use them on your child. Each time, there were baby steps at first, and I would go five steps forward and maybe two or three steps back. But I had already made a forward progression. So I knew I was getting better. And when my kids did not flinch if I raised my voice, I knew that they were learning to trust me, as I was learning to trust myself.

Mr. ANTHONY. So I hear you saying that you really learned the skill of control.

Ms. STEVENS. Control.

Mr. ANTHONY. You do not consider yourself cured, then?

Ms. STEVENS. No; I do not. I maintain that that feeling, that rage is always going to be in there. There are a lot of things that have happened and I have let go of many of them. But that feeling of rage is there. What I do with it now is very different than what I did with it 6 years ago.

Mr. ANTHONY. So you had a program that brought you in for some treatments. Through your own action with it, you feel like you have gained the inner control, you need in order to gain your family's trust?

Ms. STEVENS. That is correct.

Mr. ANTHONY. What skills have you learned from your personal experience that you could now transfer as you try to work with other parents and other abused family situations?

Ms. STEVENS. I think one of the best things I have learned is that now that I am in the capacity that I am in with Parents Anonymous and dealing with many law enforcement agencies in the county, that some of the newer parents tend to look at me as that authority figure, and that I have heard it time and again, "You could not possibly understand what I am going through." That is when I tell them my story. Then we get on about the business of changing their behavior patterns.

Like I said, we have set up a 24-hour hotline so that parents can call other parents who have been through it, who are learning how to stop. Just having that voice on the other end of the phone that says "I really understand, I know what you are going through," that probably is more important than anything, of knowing that that parent can call and say, "I put my kid in his room, I am afraid to go in there. I am afraid of what I might do." And have somebody else say, "Would you like me to come over?"

Just knowing that there is someone there that will lend that hand that is needed, I have been able to learn those skills and been able to pass those skills on. It did not happen overnight. My abuse did not start overnight and end overnight. Where I came from was 30-some years ago.

Mr. ANTHONY. Thank you very much. I think you have made a very valuable contribution to our record.

Ms. STEVENS. Thank you, Mr. Anthony.

Mr. ANTHONY. What we are trying to establish today is trying to seek solutions to this problem.

Ms. STEVENS. Thank you.

Mr. ANTHONY. I yield back to the chairman.

Mr. LEHMAN. Thank you.

Mr. LEHMAN. If there are no other questions, we will move on to Fae Deaton. If you will summarize your statement, without objection the entire statement will be submitted in its entirety for the record.

STATEMENT OF FAE DEATON, LCSW, LPC, ACCOMPANIED BY PARENT FROM VIRGINIA

Ms. DEATON. Mr. Chairman, honorable committee members, I am Fae Deaton, I am a psychiatric social worker with Community Mental Health Center in Norfolk, VA. I also have the honor to be co-coordinator of the Virginia Beach Chapter of Parents United, Daughters and Sons United, Adults Molested as Children United chapter there, and am coordinator of Parents United of Virginia. My focus is more on the local networking of what we do with our Parents United and treatment pieces, and since networking is the issue, I also would like to mention that I am on the State board of the Virginia chapter for the National Committee for the Prevention of Child Abuse, Virginia Board of Parents Anonymous, the Norfolk Committee for the Prevention of Child Abuse, and the Virginia Beach Multidiscipline Team.

In these roles, I am able to observe the kinds of networking that is necessary to provide the support services to bring treatment to the various members of the community who have experienced child sexual abuse, either as a child, and now an adult who was molested as a child, or as the perpetrator who has molested that person's own child, or as the spouse of the perpetrator and the parent of the abused child.

In Virginia we are fortunate that we have eight chapters out of the total 110 chapters that are established throughout the United States—which also does include two chapters of Parents United in Canada. There are four chapters in the Tidewater, VA, area.

Anne Cohn was mentioning the children's defense fund in the State of Virginia. We have been able to establish that under the title of the family violence fund, and have recently received funds through that and the State Department of Social Services to develop a children's play, a musical, called "Hugs and Kisses," which is going to be presented at the, I believe it is the third, national sexual victimization conference, here in Washington in April.

There are many areas of our program that are very positive. One of them is the fact that we have such a good linkage between the different components that are needed to treat this problem. We have a team we recommend be established in a variety of cities. This includes social services and the police department who go out to respond to the reports of child sexual abuse and investigate as a joint component, and very quickly then the cases are referred to therapy for evaluation and assessment, and an involvement with the Parents United support program.

As with Parents Anonymous, we have found it to be very valuable to have family members who have experienced this problem reach out to other individuals who are just coming into the system, and experiencing the effects of the shame and the horror and realization that occurs for the nonabusing parent—and for ease of conversation, I am going to use "father" for the perpetrator, even though we know now many more mothers are being discovered as having molested their children also—but we have felt such a shame, I believe, in being unwilling to look at this as a national program or problem, just as in saying, 1961, that there was an estimation of 1 in 1 million child sexual abuse cases occurring. I have over 30 such cases in my caseload who are adults now, who were molested as children then, that is, 23 years ago. The national estimate is that, supposedly, cases are being reported at 800 per million, and are occurring, according to the national child abuse figures, in 10 percent of the population.

Well, if you figure 800 people in 1 million, and Tidewater, VA, has a population of 1 million roughly, that means 99,200 people are not receiving services, are still probably being molested or having the effects of having been molested as a child.

So, as you pointed out, we have many, many areas in which we need to provide services. One is to be able to get the families to come in for treatment. The Parents United program supports the concept of the utilization of the court system and the police, because we have found in the past the families do not stay in treatment unless you have some sort of structure to keep them there long enough to be able to make the kinds of transitions and changes in their functioning and their sense of themselves, and to provide the kind of therapy that is necessary for the rehabilitation of the perpetrator, the spouse, and the victims and siblings.

I am not going to go into much more detail because I feel that this special witness who has come with me as a parent from Virginia, who is a parent and a victim, will be able to tell the story so much better because that person has lived the story.

[Prepared statement of Fae Deaton follows:]

PREPARED STATEMENT OF FAE A. DEATON, LCSW, LPC, CHILDREN'S SERVICE & SEXUAL ABUSE TREATMENT TEAM, COMMUNITY MENTAL HEALTH CENTER ASSOCIATES, VIRGINIA BEACH, VIRGINIA

EASTERN VIRGINIA MEDICAL AUTHORITY
1964

It is a great priviledge to be asked to submit these thoughts and recommendations to you on behalf of the families and individuals in the Tidewater area, as well as other individual's and families ina similar situation in other parts of our country.

In recent years the body of literature available on the etiology, dynamics of individuals andfamilies who have experienced the trauma of intra-family sexual abuse problems, how the effects of such trauma manifest themselves in the children and adults, at the time of the abuse/molest, and later in life when the children reach maturity and begin to negotiate important transitional periods in their lives, had multiplied dramatically as we have developed systems through which an individual can be linked with the systems designed to facilitate the investigation and interventions that can begin to rehabilitate the victims and their families.

The names of Vincent Fontana, Ray Helfer, Henry Kempe, Suzanne Sgroi, Ann Burgess, Nicholas Groth, Charles Gentry, Nauman Greenberg, Kee MacFarlane, David Finklehor, Lucy Berliner, Roland Summit, Karen Meiselman, Alan Rosenfeld, Frederick Green, Domeena Renshaw, Sandra Baker, Joyce Thomas, Linda Blick, Linda Sanford, and of course Hank and Anna Giarretto of the Institute of the Community as an Extended Family (ICEF), the Child Sexual Abuse Treatment Program, (CSATP), in Santa Clara County, California, and Parents United, Drughters and Sons United, Adults Molested as Children United, (PU/DSU/AMACU), the national network of family support programs for families and adults who have experienced sexual abuse, and Leonard Lieber, of the national child abuse support network, Parents Anonymous. There are other names, also well-known and respected. Time allowed for testimony did not permit the inclusion of my colleague, Dan Sandlin, LCSW, so I have taken the liberty of including a copy of our presentation at the First World Congress on Victimology, in Washington D.C., in August, 1980. Much of the essence of our philosophy is contained in that document, as well as some research results on the length of time families tend to take in moving from a dysfunctional family functioning level, to a more coping modality.

As with the parent program, Parents United, Inc, in San Jose, California, which began with two mothers of incest victims meeting together for emotional support, along with Hank and Anna Giarretto as the professionols back in 1971, the Virginia Beach Program began with a small nucleaus of four incest couples, in which the father had molested their children. Dan Sandlin had been a co-leader of that therapy group, which becam the first semi-self help support program in Virginia. He and I were asked to be the Co-ordinator/Sponsors of this group and program, and eventually also became the Co-Directors for Parents United of Virginia, Inc.

The California program has grown to over 300 members in that chapter, and there are about 60 chapters in California, 8 in Virginia, two in Canada, with the remainder of chapters in the United States making a total of over 110. Over 500 have come through the Virginia Beach Chapter, 150 in Norfolk, 70 in the Chesapeake, Portsmouth Suffolk (CPS) chapter, about 50 in Newport News/Hampton chapter, and approximately forty individuals between the Roanoke, Lynchburg, Fairfax, Fredericksburg chapters, and newly forming Woodbridge group. Richmond is in the formation stage, also.

We have been pleased and honored to have participated in the development of the Pittsburg and Philadelphia, Pennsylvania, Trenton, New Jersey, Wilmington and Dover, Delaware, Montgomery County, Maryland, and Elizabeth City, North Carolina, Chapters, as we have taken various members of our speakers bureau out to tell their story to the public and professionals in these various communities. Hank and Anna Giarretto and Art and Peggy, Parents United members and chapter development chairpersons have been a guiding force and emotional support to us all.

In the Tidewater area, we are particularly fortunate for a very sophisticated set of investigation and treatment response components in several cities.

The Norfolk Family Sexual Trauma Team was established under a Juvenile Justice grant, and continues today , with the Police component under the direction of Lt. Porter Richardson, and the Department of Social Services team under the direction of Child Protective Services coordinator, Luella Howard. This team has shared their model in the form of training with other communities. The Chesapeake Sexual Abuse Team added the innovation of filing an abuse and neglect petition at the same time the charges of the sexual abuse are filed, keep both parents under the jurisdiction and supervision of the Department of Social Services should the case not have sufficient corroborating evidence that would be acceptable in court, or if the age of the child was not able to be established as a creditable witness. Asst. City Attorney John Oliver developed this approach. Virginia Beach has also gone to the trauma team model, but has added the investigation of all forms of child abuse, not just child sexual abuse.

One of the major goals of the support program, PU/DSU/AMACU is to prevent remolest. We have found that the various members can monitor each other in and out of the groups, and are committed to the reporting of any remolest situation in the group. Particularly helpful is the use of the court system in the early portion of the case investigation. After the perpetrator is contacted, following the interviewing of the victim, and mother, the various family members are referred to therapy, for an evaluation as to level of emotional and psychological functioning, level of commitment to treatment, and in the case of the perpetrator, whether or not the abuser is a danger to society, or needs to be maintained in a highly structured environment.

In some instances, a time is spent in jail, upon the arrest, if bail is not easily available, or the magistrate feels the person is not able to be out on his own recognizance. In the Chesapeake program, all cases are sentenced to some amount of time. It may be weekends, a few weeks, months, or a year, even if the individual is making good progress in the treatment components of therapy and PU. Surprisingly, the perpetrators state that this has a profound effect on their lives to help them realize what they have done, and to help them appreciate that they have received a second chance at life. Work release is frequently used, in order for the perpetrator to continue to contribute to the support of his family, and pay taxes, etc. He is also more easily available for continued therapy, individually, as well as in marital, and eventually family therapy, if the decision of the parents is to continue the marital relationship. In about seventy-five per cent of the families, the couple chooses to stay together.

Staffings are held with the various treatment and investigative components, to determine the management of the cases, and make joint decisions regarding the best interests of the family members. Prognosis for the perpetrator is good when he pleads guilty, rather than forcing the child to testify on the stand. He also will accept full responsibility for the abuse, not blaming the child, spouse, or other factors for his problems. Where there is a great deal of anger expressed toward the system and individuals connected with these systems, we have seen the remolest occur in most instances. It's a danger signal.

Other indicators for success in treatment and rehabilitation is when the perpetrator invests himself completely in the therapy, looking at various aspects of his personality and attitudes. He also doesnot blame the spouse's lack of sexual involvement with him as justification for the sexual abuse. The father will also support the mother in seeing to it that the children also participate in therapy and the DSU programs.

The spouse also influences the positive prognosis. When she can protect the child and supports her in telling the truth, not coercing the child to change the story, or deny the charges, is able to look at her own role in a dysfunctional family system.

The child grows when she or he is able to express feelings toward the father over what has happened, as well as hear the apology from the father; recovery can occur when the mother believes the child, and insists that the child report any further incidents to her for corrective action toward the father.

Note: there are female perpetrators, less frequently reported, but just as incest was underreported a few years ago, so has the female perpetrator been under reported.

Testifying at times may be necessary for the child. This can have a therapeutic effect on the child if the issue of truth and justice can be emphasized. In some instances the testifying can add longer time in treatment for the child, but it is the lesser of two evils that the child/adolescent testify, rather the perpetrator getting off and the child being at risk for remolest.

It is sad to hear, but some perpetrator is said to have commented, in order not to, get convicted of molest charges, molest a child five and under; they don't get accepted as witnesses in court. This makes the child doubly victimized, when the perpetrator has no experience of just desserts in being caught, and the child feels that it is the adult that can break the law, and get away with it.

Another gap exists in the adjudication of cases in which it is not a parent or caretaker situation, since the parents are not under mandate from social services to carry through in treatment for the child(ren) that has/have been abused.

The child's statements may not hold up under cross examination, allowing the rights of the perpetrator to take precedence over the rights and well-being of the child.

A major gap in services also occurs for individuals who have too high an income level to have medicaid, and lack adequate insurance coverage. The military service member also is at jeopardy since no funds are set up for treatment of the perpetrator, and usually in house care may be too limited, or not adequately covered by training.

It would be extremely beneficial to have non-availability of treatment statements more easily obtained from the military. There are in the Tidewater area a number of public and private groups who specialize in incest treatment. The cases can be quickly referred to treatment once the secret is brought to the attention of the social services and or police.

Rumours have been heard to the effect that some military Directors in the upper eschalon are advocating the treating of all dependents and personnel having the incest problem in the hospital, for about a two week in-patient time, and not utilizing any community treatment programs.

In the past when treatment has been mandated to be at the military clinics, it soon became impossible to receive care in any reasonable time frame, and the uniformed personnel often are overlooked, or don't get the priority care. A shift then occurs, and the dependents are thrown on to the local market again, but the treatment services may have dried up in the meantime, placing children and families at risk.

The patient who has a thick file is often identified as a trouble-maker, rather than recognizing that such frequent visits to the clinics make a cry for help, and can be indicators of various forms of abuse, and family dysfunction.

In order to have a preventive piece put in place, local medical programs, and training components could be developed to structure preventative screenings and lectures, to cut down on the later treatment costs, by eliminating them. If the problem doesn't occur, then it need not be treated.

To return to the issue of large amounts of Champus funds being spent in large military communities, rather than bemoaning the fact, we should view the large numbers as the indication that the problem of sexual abuse is more rampant than we have wanted to believe. There are also treatment programs that can receive the families, and be networked along to have the best in rehabilitative services available. In the Tidewater area there is a resource bank listed in the Information Center of Hampton Roads. Numerous Multidiscipline Teams provide the exchange of information and referrals, smooth the linkage and accessing of services.
The Council of Agencies, Norfolk Committee for the Prevention of Child Abuse, Tidewater Allinace on Sexual Abuse, (TASA) link with the Navy Family Advocacy program to aide in keeping the military offender in the service, rather than losing many years cost of training and experience by discharging the military person. Unfortunately, the enlisted personnel are the levels that only have a good chance in staying in, if their work record has been good. The Commissioned officer is not yet knowingly given that option, and will be dismissed from the service. Commander James Ibach has made much effort to bring about the cooperative stance of the Navy in regard to retaining their personnel after such a problem is revealed.

Additional funds or insurance programs need to be developed to see to it that all families and their members can have quality sexual abuse treatment. This is a prevention move, to break the chain of abuse, by treatment.

The PU/DSU/AMACU members go out to speak to professional, civic, and community groups to let people know about the spectrum of the problem and to be living examples that people can be rehabilitated. This is certainly more cost effective than housing a perpetrator in prison for X amount of time, and returned to the community untreated, and possibly capable of molesting again. The fragmented family requires various welfare monies, again placing a burden on the citizens to pay for the families consequences.

The Parents United families and adolescents can provide a viable option as substitute for foster care placement, and as a place for the perpetrator to stay when he removes himself from the home voluntarily. This also is cost effective.
Funding to support training of professionals and para-professionals to be involved in facilitating and leadership would be a well spent set of funds. In Virginia Parents Anonymous and Parents United have looked at joint proposals, and could benefit from funds earmarked for the private sector, such as supports groups are.

It is critical that we work cooperatively, not competitively, in order to assure treatment delivery for all individuals and families, not just those that have high option insurance.

Often the adolescent seems to be hospitalized, incurring many expenses not covered by the 80% (or less) formula. Frequently the adolescent, or child only needs the support of understanding, trained "sponsors" to provide the safe setting for the child. The Support system of Parents United can provide this setting, when properly trained. Peer support, at each age level is valuable.

In the area of families well being, when it comes to the care of the retired military person and spouse, if the illness is severe enough, skilled home nursing care can be justified and come under Champus, but as the individual becomes stabilized and may not require the level of care previously needed, there is no coverage for an aide, or for a nursing home to care for the spouse, (although the retired military person may go to the VA hospital). Being able to have care in the home, which provides a familiar setting for the individual struggling with senility, or Altzheimers Desease may be the more therapeutic intervention. The nursing home may be a disorienting experience in an already confusing situation.

Should the need for Medicaid arise, the home and savings are jeopardized and may be required to be turned over to the state in return for the care in a Nursing home. Medicare is not available to the Navy person.

Child abuse, and especially child sexual abuse can be stamped out in our lifetime. It is definitely an "IDEA WHOSE TIME HAS COME."

Thank you.

Fae Deaton, LCSW LPC
Fae Deaton, LCSW, LPC
Children's Service & Sexual
Abuse Treatment Team

and Co-coordinator for the Virginia Beach Chapter of Parents United
Co-Director of Parents United of Virginia, Inc.

Member of the State Board of the Virginia Chapter of the National Committee for the Prevention of Child Abuse.

Member of the State Board of the Virginia Parents Anonymous

Member of the Norfolk Committee for the Prevention of Child Abuse

President elect, Tidewater Alliance of Sexual Abuse (TASA)

Member, Virginia Beach Department of Social Services Multi-Discipline Team.

[FROM THE PUN, VOL. VII, NO. 4, DEC. 1983]

100 - PLUS CHAPTERS

CALIFORNIA CHAPTERS

Alameda County
Butte County
Contra Costa County
El Dorado County
Humboldt County
Imperial County
Kern County
Los Angeles County
  Lancaster Paramount
  Los Angeles Pomona
  Long Beach UCLA
  Montebello Van Nuys
Marin County
Mendocino County
Napa County
Nevada County
Orange County
Placer County
Riverside County
  Riverside Coachella Valley
San Bernardino County
  San Bernardino Victorville
San Diego County Mira Mesa
  San Diego San Luis Rey
San Joaquin County
San Mateo County
Santa Barbara County
  Santa Barbara Santa Maria
Santa Clara County
Santa Cruz County
Shasta County
Siskiyou County
Solano County
Sonoma County
Stanislaus County
Tulare County
Tuolumne County
Ventura County
Yuba County

U.S. CHAPTERS

Alaska
  Anchorage Fairbanks
Arizona Bisbee Phoenix
  Coolidge Tucson
Arkansas Little Rock
Colorado Boulder
Delaware Wilmington
Florida Miami Gainesville
Hawaii Honolulu
Idaho Pocatello
Illinois
  Bolingbrook Ottawa
Iowa
  Ames Council Bluffs
  Garner West Branch
Kansas Olathe
Louisiana New Orleans
Maine Portland
Maryland
  Baltimore Kensington
Massachusetts Brockton
Michigan
  Bay City Grand Rapids
Nebraska
  Grand Island Kearney
  Omaha Papillion
Nevada
  Las Vegas Reno
New Jersey
  Mt. Holly Trenton
North Dakota
  Devils Lake Bismarck
Oklahoma Tulsa
Oregon
  Hillsboro Medford Ontario
  Portland Roseburg St. Helens
Pennsylvania Pittsburg
South Carolina Summerville
Texas
  Amarillo Houston San Antonio
Utah
  Logan Ogden
  Salt Lake City
Virginia
  Fredericksburg Norfolk
  Portsmouth Roanoke
  Virginia Beach
Washington Bellingham
Wisconsin Madison

INTERNATIONAL CHAPTERS

Canada
  Calgary Alberta
  Oshawa Ontario

PARENTS UNITED OBJECTIVE

Article I, Section 4
"OBJECTIVE" Parents United By-Laws

[This] *Chapter shall be a non-profit organization dedicated to the assistance of children, parents and others concerned with child sexual abuse and related problems, in the spirit of self-help and mutual support for those whose lives have been affectecd by these problems.*

In accordance with those purposes, we seek to promote increased public awareness, education and prevention programs, coordinated efforts by public and private agencies and increased training and education of professional workers and law enforcement agencies—so as to ensure the future handling of child molestation in a humanistic manner.

PRIDE IN PARENTING

PARTICIPANT INFORMATION
June 15, 1983 to February 29, 1984

Session One: June 15, 1983 to Aug. 2, 1983

	Mothers	Fathers	Childre
1. Huntersville Multi-Service Center	12	0	13
2. Little Creek Multi-Service Center	*9	0	7
3. Park Place Multi-Service Center	14	0	14

*One grandmother

TOTAL:	Mothers	Fathers	Children
	35	0	34

Session Two: September-November

	Mothers	Fathers	Childre
1. Armed Services YMCA	5	1	5
2. Berkley Multi-Service Center	5	0	6
3. Children's Hospital of the King's Daughters	5	4	5
4. Coronado School	*25	0	0
5. Huntersville Multi-Service Center	5	0	5
6. Little Creek Multi-Service Center	7	2	6
7. Park Place Multi-Service Center	8	0	10

*Adolescent school-age mothers-Pride in Parenting Manual incorporated into their parenting curriculum

TOTAL:	Mothers	Fathers	Children
	35 *25	7	37

Session three: November-January

	Mothers	Fathers	Childre
1. Berkley Multi-Service Center	10	0	10
2. Children's Hospital of the King's Daughters	8	3	8
3. Huntersville Multi-Service Center	3	0	3
4. Little Creek Multi-Service Center	9	1	9
5. Norfolk Adolescent Pregnancy Prevention Services	8	0	8
6. Norfolk Community Hospital	6	0	6

TOTAL:	Mothers	Fathers	Children
	50	4	50

Session Four: January-March

	Mothers	Fathers	Child
1. Norfolk Adolescent Pregnancy Prevention Services	8	0	8
2. Norfolk Community Hospital	9	0	9
3. Norfolk General Hospital	8	8	8
4. Saint John's Luthern Church	16	1	30

TOTAL:	Mothers	Fathers	Children
	[illegible]	[illegible]	[illegible]

SESSION FOUR: Continued

TOTALS:	Mothers	Fathers	Children
	45	9	49

GRAND TOTALS (The numbers noted will represent the combined totals of all mothers, fathers, and children from each session)

Mothers	Fathers	Children
190	20	146

*25 mothers included in the 190 total under mothers are from the Coronado School

TOTAL POPULATION SERVED FROM THE PERIOD BEGINNING JUNE 15,1983 to February 29, 1984:

This number will include all mothers, fathers, and children served in the city of Norfolk:

196 mothers
20 fathers
152 children
368 Total

*The Pride in Parenting Program offered parenting education, infant stimulation, and support activities to twenty (20) Navy families living in Norfolk.

TOTAL FAMILIES SERVED IN THE CITY OF NORFOLK FROM JUNE 15,1983 to February 29,1984:

368 divided by 2 =184 Families

Help For Sexually Abused Children And Their Families

P.O. Box 2222 • Virginia Beach, Virginia 23450

*******PARENTS UNITED*******

*******DAUGHTERS & SONS UNITED*******

*****ADULTS MOLESTED AS CHILDREN UNITED*****

PARENTS UNITED

Parents United is a self-help, non-profit corporation dedicated to the assistance of parents, children, and others concerned with child sexual abuse.

Parents United began under the direction of Hank Giarretto, Ph.D., in Santa Clara County, CA. It is the best known nationwide organization representing the interests of sexually abused children and their families.

Members of Parents United and its components, Daughters and Sons United (DSU) and Adults Molested as Children (AMACU), are or have been involved in entra-family sexual abuse. These include offenders, spouses of offenders, children who have been molested, adults molested as children and others (siblings, step-parents, spouses of AMAC's). Parents United works closely with the Department of Social Services, the Judicial system, and other professional agencies to ensure the handling of child molestation in a humanistic manner for everyone involved.

Parents United began in Virginia in 1979 with eight members and has served over 200 individuals whose lives have been affected by sexual abuse. The professional staff consists of volunteers who devote their time and energy to facilitate groups and train sponsors. Professionals and sponsors perform administrative and facilitator functions and train professionals along the East coast.

Parents United provides an opportunity for individuals to explore the factors that might have contributed to the sexual abuse and work through the damage caused. It provides a support that is not available elsewhere.

Parents United, the Department of Social Services, and therapists work hand-in-hand so that families can remain together whenever possible. By informing the public of the existence of Parents United, we can extend a helping hand to anyone who has experienced this trauma.

EFFECTS

Immediate effects are feelings of fear, shame, helplessness, betrayal, confusion, and depression. The child displays dramatic changes in personality. School attendance and grades may suddenly change. The child may see herself as a willing participant, leading to feelings of guilt.

Family members usually feel rage, hostility, guilt, embarrassment, and helplessness. Sometimes the child is not believed, or may be blamed for the incest. Sometimes the family system will "close" in efforts to protect what appears as family togetherness. The family is in crisis.

Long-term effects may include difficulty in forming intimate relationships, low self-esteem, predisposition to becoming repeatedly victimized, marital, sexual, and identity problems, antisocial behavior such as drug/alcohol abuse, promiscuity, delinquency, running away, and suicide attempts.

FACTS

1. Current reports indicate that over 80% of sexually abused children are female.
2. The average age of the victim is 6 to 11 years of age when the incest begins.
3. A large majority of prostitutes and incarcerated persons have been victims of incest or other sexual abuse.
4. Daughters often blame the mother for not protecting her even though the mother may be unaware of the problem.
5. Over 50% of offenders were sexually abused as children.
6. Offenders often rationalize the abuse as "showing love" or "teaching" a child about sex.
7. Offenders and victims may feel powerful and become manipulative - using blackmail, bribes, or "favors" to get and keep control.
8. Sexual abuse is treatable and controllable - not curable.

ADULTS MOLESTED AS CHILDREN UNITED

Adults Molested as Children United (AMACU) are men and women who were sexually abused as children by those in authority over them such as parents, grandparents, aunts, uncles, teachers, older siblings, and/or others. Many have spent years in therapy or in institutions. Many have not had the opportunity to have access to therapy. Often they have difficulty in maintaining lasting relationships and holding jobs.

AMAC's, like younger DSU members, often think they are alone, that no one knows what they have been through. Finding others with whom they can share their feelings and experiences eases the burden they have carried, often for many years.

Contact with AMAC's presents an opportunity for parents, including offenders, to see the long range effects of untreated child sexual abuse. These include feelings of pain, anger, fear, abandonment, shame, isolation, and betrayal. This helps victims as well as other adults (such as step-parents) who are parenting sexually abused children.

Parents United also provides an opportunity for AMAC's to confront mother/father figures in groups-directly or in role-playing. Death, separation, or fear may prohibit an AMAC from confronting their abuser directly. They may confront their abuser by writing to them or they may use role-playing to release their feelings.

AMAC's also participate in speaking engagements. They help open closet doors and let people know that child sexual abuse does exist and that there is a place where people can get help. They reach out to other victims to let them know they are not alone.

Professionals are able to redirect negative feelings and behaviors toward positive and constructive activities. AMAC's learn to be independent and assertive which leads to personal growth and helps in everyday life and in their careers. This enables the victim of child sexual abuse to help themselves and others become "survivors".

WHAT, WHO, HOW?

Child sexual abuse is any sexual activity between an adult and a child. It ranges from touching, fondling, and indecent exposure to sexual intercourse. The line can usually be drawn between affectionate intimacy and inappropriate sexual conduct when it is felt that the contact has to be kept secret. It is considered to be a psychological illness which, with proper treatment, can be controlled, but is not curable.

Victims are children. They live with parents, relatives, in foster homes, group homes and shelters. They go to school, work, read, laugh, dance, and play sports. They are children who differ in that they have been sexually abused. In the large majority of reported cases, the victims are girls - the offender more often reported is the father or "father figure". Although we usually refer to the victim as "she" and the offender as "he", there are many victims who are boys and many women offenders.

Adults who become sexually involved with their children are usually "basically good people". They are often under stress, feel isolated, have low self-esteem, and poor impulse control. They need help and want help, but are ashamed and don't know how to deal with what is happening. Sexual abuse occurs in all social, economic, racial, cultural, and religious groups.

Sexual abuse often evolves slowly within families and is likely to persist over many years. It usually begins with the eldest daughter and continues with subsequent female children. It often begins so subtly that the child isn't aware that the behavior is abnormal. Sometimes the child is manipulated by the promise of reward, and sometimes with threats of punishment if she does not cooperate, or if she tells. The child may also feel sexual pleasure which later leads to feelings of guilt and role confusion, which may affect them the rest of their lives.

DAUGHTERS & SONS UNITED

Daughters and Sons United (DSU) is a component of Parents United. It is a community of young people who provide member-to-member support, understanding, caring, and help to others through times of crisis and readjustment.

DSU members find that they are not alone. They find others who have similar experiences and feelings. They find a safe place to open up, knowing they will be accepted and understood. They support each other, listen and learn from each other, and are better able to understand themselves and their families.

Members meet regularly under the leadership of professionals who lead discussions of issues relevant to their physical and emotional health and well being. They deal with feelings of guilt, hurt, anger, love, confusion, resentment, happiness, and pain. They help members talk about these feelings and the changes that are happening in themselves and their families. Professionals also educate young people in areas of social behavior, identity, sexual relationships, venereal disease, birth control, and respect for themselves and others.

They may participate in speaking engagements to educate the public and to encourage an understanding of families troubled by child sexual abuse. They give information about DSU and themselves by sharing as much personal information as they feel comfortable with. They hope their efforts will make it easier for children and parents to seek help and stop further abuse.

Goals deal with enhancing self-esteem and self-determination. This leads to independence which helps prevent reoccurrences and future problems with emotional and sexual relationships.

WARNING SIGNS

1. Child insists on going everywhere with mother.
2. Child becomes withdrawn, cries easily, or becomes promiscuous.
3. Child becomes self-conscious of body. Hygiene deteriorates or excessive bathing. Possible genital irritation or infection.
4. Child acquires "adult-like" behaviors.
5. Child becomes controlling and/or demanding within family.
6. Offender becomes overprotective of child, pays overzealous attention, controlling all aspects of child's life.
7. Offender becomes too familiar with child's body.
8. Offender spends money on, or gives money to child.
9. Offender has secretive conversation with child -disappears when child disappears.
10. Offender constantly seeks approval of self as "o.k."

Any, some or all of these signs may be observed.

WHAT CAN I DO? HOW CAN I HELP?

Many parents believe their children will be safe if they don't talk to strangers, but the usual offender is a member of the household, a neighbor or friend of the family, or a person with whom the child has frequent contact.

We can teach our children how to say "no" to anyone who causes them to feel uncomfortable, and not force them into physical contact when they don't want it - like kissing Grandpa goodnight. We can begin to discuss sexual abuse openly with each other and our children. We can talk to school officials about developing programs to include information on sexual abuse and prevention, integrating it into a general curriculum of sex education. Programs should begin in grade school.

If a child tells you she is being sexually abused, BELIEVE THE CHILD. Assure the child that it is not her fault, and that she was right to tell you about it. Tell the child you are sorry this has happened. Assure that the child is no longer in danger and REPORT the abuse immediately. If you even suspect that a child is being abused, you have

REPORTING

yone can report known or suspected abuse by calling any of e following numbers. You need not give your name when alling. All reports are kept confidential.

EPARTMENT OF SOCIAL SERVICES

hesapeake - 543-9211
ampton - 722-7931
ewport News - 247-2300
orfolk - 583-4331
ortsmouth - 393-9500
uffolk - 539-0216
irginia Beach - 486-7223

AMILY SEXUAL TRAUMA TEAM (Norfolk) - 587-2592
ONTACT TIDEWATER - 428-2211
NTERACT - 481-2828
AVY FAMILY SERVICES CENTER - 444-NAVY
EXUAL ABUSE HOTLINE (Richmond) - 1-800-552-7096
hesapeake Sexual Abuse Trauma Team 543-9211
irginia Beach Sexual Abuse Team 486-7223

HAPTER SPONSORS/COORDINATORS , PU/DSU/AMACU, Tidewater Area******

HESAPEAKE-PORTSMOUTH-SUFFOLK - Martha Hodge 1-539-0216
AMPTON-NEWPORT NEWS - Mason Price - 1-595-4435
ORFOLK - Luella Howard - 627-4861
IRGINIA BEACH - Fae Deaton - 446-7410/446-5067
Carol Jackson - 1-539-0238
Dan Sandlin - 481-2298

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Sexual Victimology of Children within the Home: A Treatment Approach

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SEXUAL VICTIMOLOGY OF CHILDREN WITHIN THE HOME: A TREATMENT APPROACH

The effect of intra-familial child sexual abuse is profound and traumatic. The primary victim is the child, but the "victimization syndrome," unfortunately, extends much further, with devastating effects on the family as well, but moves extensively to other areas, touching upon professionals within legal and service providing agencies in adversive and painful ways. We would like to address these aspects of victimization of the child, the family, and the more subtle and undercurrent effects as experienced by professionals in the fields of mental health, social welfare programs, and legal systems. We will also present a comprehensive treatment approach, which minimizes the traumas, difficulties, and frustrations of both families and involved professionals alike.

THE VICTIMIZATION OF THE CHILD

In the past few years, there has been increasing literature describing the processes of intra-familial child sexual abuse, causation theories, short-term and long-term effects of the sexual maltreatment. In incestuous cases, present data indicates that the most prevalent damaging situations occur between father and daughter or stepfather and stepdaughter. Most recent information indicates that the sexual victimization of male children is more prevalent than earlier data provided.

In terms of sexual involvement, the most common reaction of the sexually exploited child is that of "passive resistance" of being "persuasively coerced", in which the child participates through a conditioned process, which includes the elements of over-closeness and intimacy progressing to the acting out of sexual fantasies, impulses, and urges by the parent, with characteristics of stimulation, curiosity, confusion, and fear on the part of the child. Some children are passive out of fear of and punishment by the parent. This highly troubling situation, wherein the child has positive feelings for the parent, but negative feelings for the provocative sexual invasions and relationships, leads to a severe state of ambibalence and contributes in part to the child's immersion into a state of "disturbing silence," with reluctance and resistance to report what is sexually occurring to her or him. The child may also fear that disclosure of the incest will totally destroy the family unit. The child may want to protect family members, particularly the non-abusing parent, from the anguish and pain of the sexual maltreatment, while wondering, "Why is this happening to me?"

Emotionally, the child often experiences guilt, anxiety, shame, fear, repulsion, and inhibited rage. From our clinical experiences, we have heard victimized children and adolescents and adults molested as children give the following descriptions: "I still feel tarnished and dirty." "It was ugly and the memories are just as ugly and disgusting." "I feel helpless and scared - what could I do?" "It was depressing and I get depressed now just talking about it - I just don't know how to handle it."

Without therapeutic intervention, and unfortunately even with such interventions in some cases, the long-term effects of intrafamilial child sexual abuse can be devastating. In some, probably most, cases, incidents of child sexual abuse influence the "emotional world" and behavior of the victim for the rest of his or her life. Possible long-term effects include the repetition of self-destructive behavior patterns, such as drug and alcohol abuse, runaways, suicidal acts, and sexual dysfunction.

The child/victim continues to experience severe difficulties and a different kind of abuse, an abuse by the environmental systems. Within the family, the victim may be "scapegoated" by family members. The victimized child is often the family member who is removed, placed in a foster home, a crisis home, a regional group home, a hospital. Unfortunately, little attention is give to the further trauma that the child or adolescent experiences when required to testify in the court system. The child is also victimized when she or he is pressured by the parent or parents to change or modify vital information related to the incestuous relationship; this matter occurs more often than we would like to believe.

THE VICTIMIZATION OF THE VICTIMIZER

In a broad sense, the perpetrator is victimized by his or her own psychological pathology. We have witnessed many of the parental offenders describe their own "loss of control hell," feeling driven by frightening impulses and urges. They describe feelings of self-hatred and self-disgust. It is not unusual for these parents to experience a sense of relief when the incest is exposed. The abusers themselves are also victimized by insensitive and inhumane social, legal, and mental health systems. (It is important for us to identivy these offenders as those persons who are motivated and capable of rehabilitation, not the smaller percentage of perpetrators who are untreatable, such as the psychopathic personality, and definitely require removal from society.) These offenders, identified as treatable, are also victimized when clinical services are non-existent or inadequate, when professionals are not sufficiently trained to work effectively with this particular population. Victimization occurs when the lack of public funding prohibits specialized treatment for the offenders who are either poor or who have no insurance to cover therapeutic intervention.

THE VICTIMIZATION OF THE SPOUSE

The spouse, usually the mother, from overall reporting resources and from out clinical experiences, is also victimized in the trauma of incest. There is a conditioning process that occurs in the family dynamics, wherein the wife is somewhat of an "outsider," certainly during the period that the sexual exploitation occurs. The wife/mother often feels "doubtly betrayed" when the incenst is exposed. Some of the emotional responses that we have heard vary in a wide range of feelings and experiences: guilt, anger, hostility, confusion, denial, outrage, fear, depression, despair. Guilt is inherent in questions like "What could I have done to protect my child?" "What was wrong that my daughter could not have come to me?" With these spouses, it is not uncommon that dormant neurotic conflicts arise, resulting in some degree of emothional disturbance, requiring indepth psychotherapy. This spouse may be torn between loyalties to both her husband and child, creating a deep and disabling sense of ambivalence. She is often under severe criticism from family members, neighbors, friends, if she choose to remain with her husband with the attempt to resolve the family problems. In essence, she is "scapegoated" by significant persons in her life if she makes certain choices, which adds to her own sense of emotional isolation, pain, and self-perception of being a failure as a wife and mother.

THE VICTIMIZATION OF THE FAMILY MEMBERS

Whether the incestuous behavior is exposed to the other family members or not, they certainly affected by the traumatic course of events. Importantly, they are a part of the dysfunctional family system itself. Even when the parents attempt to keep the incestuous situations secretive, the siblings of the victim realize that something is seriously wrong. They witness a chronically distraught, weeping mother and a depressed, frightened father; they are confused when either their father or sister suddenly leaves the home. When they are told of the sexual abuse, they are overwhelmed with a wide mixture of emotions and reactions: anger, depression, fear, confusion, distrust, resentment. We have worked with sisters of the victim, who have expressed fear and terror that they too will become victims. We have also been aware of sons of offending parents, who have raised the question, "Will I do that if I have children." These family members are definitely victimized by the betrayal within the family through incest and suffer the consequences of a family in turmoil.

THE VICTIMIZATION OF THE PROFESSIONALS

Professionals, encompassing legal systems, social service agencies, mental health facilities, law enforcement programs, are imobilized and often suffer the "burn-out syndrome," in attempting to work proficiently with incestuous victims, perpertrators, and the various family members. These professionals often carry overly-large caseloads, and lack specialized training and education. Competitiveness between professionals in clinical services, particularly for clients who can pay or who have insurance, can interfere with the comprehensive treatment for all victims and their families. Professionals, without specialized training or orientation to incest cases, are often forced to handle these cases. Others insist on working with these families out of their own needs to be seen as qualified to work with "all kinds of cases." Unfortunately, these workers may deny their own discomfort and resistance in working with incestuous families. Ultimately, both the workers and the families will suffer.

THE TREATMENT APPROACH AND PROCESS

The psychological treatment as implemented in this model is multifaceted and begins as soon as possible after the intra-family sexual abuse has been reported. The families involved in incest are so troubled and dysfunctional that a traditional approach to therapy or counseling would usually be inadequate. Therefore, an organized implementation of various services will be described. These services include: (1) a Sexual Abuse Treatment Team, consisting of professionals representing the public and private sectors, in the fields of social services and mental health. Case staffings, program design, information sharing, and collaboration of clinical goals are examples of duties of this team effort. An important function of this team is to provide an ongoing opportunity for the professionals involved to continually explore their own feelings and reactions to the whole phenomenon of incest and its turbulaent effects on the family. Because of the nature of the deep emotionality involved in incest cases, we take the position that we, as professionals, need to repeatedly process our own attitudes and responses for further growth and development in this field, and to be helpful and supportive to each other in the learning process. (2) An Advisory Council on Incest has been established, which includes judges, attorneys, social workers, therapists, detectives, and correction field personnel. This council, which meets on a quarterly basis, serves as an excellent vehicle for communication, collaboration, mutual goal-setting, and problem-solving. The following questions, as raised in this council, give examples of topics that are discussed and explored for productive solutions: How can cases be quickly expedited within the court system, rather than dragging on for months? How can the child be spared the trauma of court proceeding as much as possible, considering the present procedures regarding testimony? Can these procedures be changed for the welfare of the child? How can clinical services be provided for incestuous parents who are in jail or prison? What is the role of the social worker, of the therapist in courtroom testimony? What is the function of the guardian ad litum?

(3) A Sexual Abuse Help-Line has been initiated and serves the general public, with counselors available to accept telephone calls at given hours during the day and evening. At other times, a taped message is available. Besides serving victims, family members, including the perpetrator or potential perpetrator, and adults sexually molested as children, the Help-Line counselors are also enabled to impart general information regarding intra-family sexual abuse to professionals and interested citizens. (4) Psychotherapy is provided by therapists in both private and public sectors, and they work cooperatively with the Sexual Abuse Treatment Team. Upon referral of cases for treatment, therapists have the responsibility to see the families as quickly as possible, preferably within 24 hours. The therapist should be skillful in crisis intervention techniques in order to effectively deal with emergency situations, which are often the case with these families in the aftermath of the incest exposure. The treatment actually begins with the utilization of the telephone call by the victim, perpetrator, or other family member. The modalities of treatment in this program are described as follows:

Individual Treatment. The victim, offender, and non-abusing parent of the victim usually need individual treatment on a long-term basis. We are more and more aware of the need of individual treatment for other members of the family, such as siblings of the victim, depicting the reality that every family member is traumatized by the problem of incest. Treatment with Dyads of the Family. This form of treatment often focuses on the bonding of the mother-daughter relationship in psychotherapy. Another dyad of treatment may be aimed at working with the victim and the offender. One of the most important dyads is the mother-father relationship in couple therapy. Whether the parents attempt to keep the marital relationship intact or whether they make the choice of separation, therapeutic work with husband and wife is often necessary. Group Therapy for parents and also for the children has proven quite effective; for our model, the use of the group approach is used with the self-help components, Parents United and Daughters and Sons United, and will be addressed spearately in this paper. Family Therapy is another modality which may be utilized selectively in incest cases, wherein the therapist may work with the entire family or subgroups of the family. Usually, family therapy is utilized in incest cases after indiviudal and couple therapy have been implemented.

Parents United - Self-Help Group

A chapter of Parents United was developed in July of 1979, from a therapy group of four couples whose husbands have been involved in intrafamily sexual abuse with their daughters. Following the general foremat of the Giarretto program in Santa Clara County, California, the group has grown to an average attendance of 40 individuals, including the victimizer, spouse (single or married), and adults who had been involved in incest as children, but are not now experiencing incest in their lives. As of August 1980, 114 individuals had come to the meeting, recently, the program is being included in the court ordered attendance package.

The groups include an orientation group for couples or individuals new to the program, a women's and a men's group, and a group for men, and one for women, who had been molested as children. About fifty per cent of the victimizers and spouses have been molested as children.

There is also a sub-componant for the Daughters and Sons to have their own groups.

The parents' act as sponsors to new families or individuals entering the various systems involved with the reporting of the intrafamily sexual abuse. The sponsors model proper behavior and attitudes, and confront inappropriate behavior and attitudes, as well as providing emotional support and an opportunity for tension release for the new individuals. By helping others, the parents take part in their own therapeutic process and healing.

All of the Parents United groups are facilitated by professional social workers and other therapists, assisted by Parents United members who take the sponsorship, leadership, and speakers' bureau training. There are various criteria for the parents to be able to be a part of the training, and on going supervision is provided for the parents as well as the professionals. There is no charge for attending the Parents United groups. A number of the parents have spoken before professional and para-professional groups, another piece in the healing process.

A Study of a Child Protective Service Unit's Sexual Abuse Cases

A study was developed in early 1980 to examine the cases in the Child Protective Services (CPS) Unit of a Virginia Department of Social Services. A family functioning task assement tool was utilized, evaluating ten areas with possible levels ranging from 1 to 5, with three considered as the normal level of functioning. The instrument used was the Family Task Assessment Scale, develope by a faculty at Norfolk State University in collaboration with the University of Tennessee Birth Defects Evaluation Center. Reliability has been established for all task levels at the .75 level as above. All coding was computed by the researcher, which introduces a bias, but it was considered to be of more value to know the families and be able to complete an accurate assessment.

Fifty-one cases were in the CPS unit at the time the cases were selected. Initially, the cases were alphabetized and assigned sequential numbers. A total of ten cases were then randomly selected from calls that had been grouped over the years 1978 - 1980. The cases drawn by this method did not provede enough cases with sufficient time frame to provide comparisons over a year. Twenty-five cases that had been reported from January 1 and April 15, 1980, were in the caseload of the two social workers specializing in sexual abuse investigation, 25 cases from 1979, and three from 1978. Other cases are known to have been transferred to foster care and family stabilization units, but were not included in the CPS study.

Ten cases had been drawn originally, and an N of 19 cases was achieved by the selection of cases that would allow 6 months or a year's comparison.

An examination of these cases indicated an improvement in functioning in seven out of the ten areas by 50% or more of the families by an improvement of .5 or better. The areas examined were: Daily Management, Socialization, Self Control and Discipline, Problem Solving, Emotional Support, Tension Release, Extra Family, Resource Development, Health Care, and Intellectual Development. The first seven areas listed were the ones in which the improvement was made as described above. The three remaining, did not show an improvement. In these areas 50% or more of the families made no improvement.

Eleven cases provided sis month's data for comparison purposes, and eight cases, for the year's comparison. The cases were reviewed at the point of entry, six months, and one year, and the difference computed. The difference between six months and one year was also computed.

Although we were working with a limited number of cases, a number of interesting pieces of information did appear. Even after a year of the case being open, although the functioning levels increased, no family had reached a three level at that time. The mean functioning level at entry point was 1.46, at six months, 1.74, and at one year, 1.93. The highest score at one year was 2.50, and the lowest, 1.20. A decrease in functioning level was noted in two families. Lack of involvement with the court and Parents United was noted in these two cases.

Of the earlier cases, when the abuser was not involved in the court process, or failed to become involved in Parents United, or dropped out of Parents United, a lower level of functioning was seen in some cases, the problems increased and/or became worse. It is also noticed that these families cannot be served in a ninty day service plan, but require specialized pieces over possibly a two year period. It may be, too, that additional pieces need to be developed to assist families in resource development, health care and intellectual development. This could mean vocational and educational rehabilitation and counseling, for the adults and adolescents. Assistance in funding treatment costs, and health care would appear needed.

The lack of a three level at one year would indicate the need for the case to remain open for longer periods of time, and involve long-term, more intensive casework than other forms of child abuse might need. It would also require the social worker to have fewer cases due to the complex and sensitive nature of the problem. Can a social worker continually be called upon to go out and investigate new child sexual abuse reports, and continue to monitor and provide services to the family at the same time? Certainly without the additional staff to assist in the caseload, quality service seems unreasonable. This worker might be carrying some of the investigative load as well as on-going case work, or take on the ongoing service, and leave the investigative work to individuals who would specialize in the initial phases of intense work with the new cases/families, a particularly traumatic time for all involved, worker and family alike. Specialized case workers are needed during this time. A worker may also be involved in advocacy and individual and family casework on an intensive basis, as well as having the family involved in a complex schedule of therapy.

The utilization of the self-help group assists greatly in several of the task areas' improvement, in particular, emotional support and tension release, and socialization. An improvement in the stress from extra family events and facilities is also aided by the support and involvement of self-help sponsors, as they share an understanding of the effects and process of the social services and court systems, and are able to provide appropriate models for working with thes systems. Socialization role issues, and self-control and discipline are also aided here.

Although there are many biases in this study, it is felt that many of the implications drawn from the limited findings are valid for making recommendations for continuing the casework that is now provided, and expanding the present model to continue the present pattern of improvement achieved by most of the families.

Changes in Sexual Abuse Case Assessment Averages: Entry, 6 Mos., 1 Yr.

Cases Ranked on Entry Point Assessment Averages of Totals of Areas

	AVERAGE TOTALS			DIFFERENCES BETWEEN TOTALS		
	I	II	III	A	B	C
	1.90	2.25	2.50	.35	.60	.25
	1.75	1.95	2.40	.20	.65	.45
	1.60	1.60		0		
	1.60			-		
	1.50	1.50		0		
	1.50			-		
	1.50			-		
	1.45	1.85		.40		
	1.45	1.70	2.10	.30	.70	.40
	1.45	2.00	1.95	.55	.50	-.50
	1.45					
	1.45	1.45	1.45	0	0	0
	1.45			-		
	1.45			-		
	1.40			-		
	1.40			-		
	1.35	1.75	2.00	.40	.65	.25
	1.35	1.50	1.20	.15	-.15	-.30
	1.25	1.60	1.85	.35	.60	.25
$\overline{M}$	1.46	1.74	1.93	.25	.47	.24
Mdn	1.58	1.85	1.85	.35	.20	.10
Mo	1.45	1.60	None	.40	.65	.25
		1.50		.35	.60	
N	19	11	8	11	8	8

Key:
I. - Entry point task assessment average
II - Six months task assessment average
III - One year task assessment average
A - Differences between I & II (Entry Pt. and 6 Mos.)
B - Difference between I & III (Entry Pt. and 1 Yr.)
C - Difference between II & III (6 Mos. & 1 Yr.)

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Mr. LEHMAN. Thank you.

Before we go to the next witness, I would just like to say, my own personal feeling is that I am a little bit troubled about testimony from an anonymous witness. I have been with a number of committees, and subcommittees since I have been in the House, and I have never had this happen before. Everybody has usually come forward and been able to assume who they are, and the presumption has been they would tell the truth, the whole truth, and nothing but the truth. But I certainly appreciate the courage of our next witness, who is willing to come forward to tell his story. It is unfortunate that in our society some individuals who have gone through experiences such as our next witness, have been unable to identify themselves in a forthright way without being personally stigmatized and their families and themselves diminished by coming. Well, let's say out of the closet.

I feel that this gentleman's statement would have had a great impact if it had been identifiable, but I certainly agree with the request. I cannot speak for others on the committee, but I think I would not be honest in my own feelings if I would not put my personal caveat in there that I think that such testimony from an anonymous witness to me would not carry the same weight as it would have it if had come from a witness that was fully identifiable.

Ms. DEATON. I think the issue is that in the Tidewater network we have the cable network and since we are being covered by cable——

Mr. LEHMAN. I understand, but I think the needs outweigh my own troubles about including in congressional testimony anonymous testimony. We will hear from the gentleman from the Tidewater. Would the anonymous gentleman begin to make his statement for the record as soon as the microphones are moved to that area.

Ms. DEATON. I would like to add that I have submitted some additional materials for your perusal.

Mr. LEHMAN. It will be without objection, submitted in full for the record.

Mr. BLILEY. Mr. Chairman, I have some questions for Ms. Deaton, but I will submit those for the record, and she can respond to them.

Mr. LEHMAN. I do, too, but I will wait. Then we will have questions and answers both of them together, if you would like to ask them then.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. LEHMAN. Ready?

STATEMENT OF A WITNESS, A PARENT FROM VIRGINIA

The WITNESS. I am very honored to be here. There are feelings of being nervous, shameful, a lot of stigmatism attached to my past. But I will continue with my story.

I was raised in a Christian home. There was a feeling of lack of being a part of the unit. I don't know why that is there. I am trying to still dig into that.

I was molested in my midteens by a friend of the family that was 10, 12 years older than myself. There had been a lot of trust factors involved. I put up with that for a period of months. Got married and started raising a family. There seemed to be a lot of need to control the situation.

I molested my daughter for a period of 8 years. My case came out in 1980. There was some time of denial, maybe 12 hours of it before I was broken down by a very professional social worker that cared about stopping child abuse. As soon as I started admitting when I had done it, I felt like the weight of the world was off of my shoulders. I was very ashamed of what I was doing, but there was no implementation of self-control there.

Within 3 days I had been involved in my first therapy session, my first meeting at Parents United, and I had been involved in the legal system in the booking and so forth. I signed a confession totally accepting responsibility for what I had done. I found that being in Parents United, my first meeting was very scary. I felt like I was the only person in the world that did such a horrible thing. Yet when I walked in, Parents United had been formed on the east coast here maybe for about 6 months, and there were about 30 or 40 members.

After several meetings, my wife started attending. There were some victims present in our midst, adults molested as children. Listening to their stories helped me get in touch with possibly what my daughter was going through, my wife, and my son.

I guess I first started having to admit to myself I had a problem before I could even work on it. Accepting total responsibility for what had happened. There were many times, that mentally I would try to come up with excuses. But being in therapy, when I left the therapist's office, I didn't just leave him there. When started BS'ing myself and starting coming up with excuses, my therapist's voice would kind of click inside like a tape recording and say: "What are you feeling inside? What are you doing?" And I would finally get in touch with what was happening then.

To me the hardest question asked by my therapist was: "What are you feeling right now," and I couldn't answer him. There was a lack of awareness of what was being stimulated, what was inside of me, what makes me up. So since then I have been able to build those awarenesses to where I try to stay aware of what I am feeling 24 hours a day, at least during my waking hours.

I have consistently tried to work on my problems, and I see them as growing the rest of my life. I see them as attitude changes. I haven't taken something completely out of my life. I still have times of self-centeredness, times of irresponsibility, times of immaturity. But I think, for me, trying to find the center of the road is where I am at with my life. There was a large time there when I was trying to find the why. Why did I commit incest. I found that that was a stumbling block in my growth. It was just something else that stopped me working on my problems.

The system that I was in had me charged with a felony. It was kept in a lower court system and reduced to a misdemeanor of contributing to the deliquency of a minor. I was sentenced to 2 years in prison, suspended, on the condition I continue therapy with Parents United until the professionals say that I don't have to attend any more.

Involvement for the whole family is a need in therapy. My wife and daughter were involved, my wife still is. My son never was. He is still a victim of incest. The attention I didn't give him has been detrimental to his growth as a mature person. I relinquished all my control and responsibilities of telling the children what to do in the house which laid a larger responsibility on my wife. But that is where I was. I had told them so many things for so many years that were lies, "I love you," but turn around and abuse them again. So I had to start a new vocabulary, also.

Earlier one of the witnesses mentioned about the sound bringing awareness to her. One night my son had been drunk, and I went in. And I was very angry and I picked him up and dropped him on the floor. He was about 16 at the time. He was passed out drunk. The sound of him hitting the floor sparked something inside of me as to what do I want my children to hear from me? I have been so intimidating to them all of their lives. Do I really want them to know I really care for them as human beings? Just what do I want?

So I started having to work on my facial features, volume of my voice, my hands. What am I telling them versus what do I really want them to feel for me? So, since 1980, my children have been able to see some changes in my life. There have started to be some trust factors rebuilt, and it is a neat feeling. It is a large responsibility I feel on my part, which I never felt before, to have someone's trust and not use it.

I guess right now it is a time where I am always confronting myself. Am I being honest with me? Am I being honest with my therapist?

And I feel it will be a lifetime of growth and continuing to confront myself. I don't feel that incest is curable. I feel it is controlable. I don't feel that it is—I feel that it is generational. If I can help my children in building some awareness and self-control, and building their maturity and consciousness of somebody else's right, seeing children as human beings with their own rights, there is a possibility they can grow up to not be perpetrators, also. Thank you.

Mr. LEHMAN. Thank you.

I would like to yield at this time to Mr. Bliley.

Mr. BLILEY. You said that you had failed your son. He is how old now?

The WITNESS. He will be 21 in August.

Mr. BLILEY. I see. You have not been able to involve him in the therapy?

The WITNESS. At the time, like I said, I had relinquished all control and responsibility. There were times he went to a therapist twice, but he was acting out with pot, and the two times he did go, he was still coming down off a high, and he wasn't honest. He didn't want to go. It was a reluctance in going.

He still has an attitude that he doesn't have any poblems. Now, when he does have problems in his married life, then he talks about going to therapy. But, of course, when things get better, then there is no need and he doesn't see his problems.

I think for me being in therapy, being confronted in Parents United has helped me understand that other people can see things that I not necessarily can see in my own self. And I need that confrontation. He needs that confrontation he can't see it either.

Mr. BLILEY. Is your daughter still at home and your family still together?

The WITNESS. My wife and I are divorced. My daughter just turned 18. She is living with a friend that is a friend of my ex-wife's. She has started to build some maturity, some responsibility. And that is where she is at with that right now.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. LEHMAN. Mr. Anthony.

Mr. ANTHONY. I have no questions.

Mr. LEHMAN. I have a few questions for Ms. Deaton I will submit for the record. But I would just like to recall two statements that the gentleman made. One was you said the problem was generational. Does that mean that you would think that it moves from generation to generation by people, each generation observing what happens to them or do you think there is a genetic factor involved, and a predisposition to incest?

I would like to ask the anonymous gentleman that. Did you hear what I said? I will repeat the question.

The WITNESS. OK.

Mr. LEHMAN. You mentioned the word "generational." I wanted to know whether that means that it was generational in the sense that one generation picks up incest from observation, or being part of the act, and passes it on to the next generation, or do you mean that there is a genetic predisposition in the person that is inherited that would lead them to these incestuous practices.

The WITNESS. OK. One thing I didn't bring out was that 8 months after my case came out, we found out that my dad had also molested both my kids. All right.

After digging into his problems for the first time in all of my life, I found out that his dad molested him. I wasn't aware of any of that.

I can use a lot of things as excuses. It is generational. I did it because my dad was molested. But, for me, I don't feel that it is anything except my own responsibility in what happens. There was a lot of low self-esteem. I acted out in a sexual way. For me it is not a sexual problem. I am not stimulated sexually with kids. I do have problems with fantasy. I do have problems with stress. I didn't act out with alcohol or drugs. I did act out in extramarital affairs. I didn't act out in physical abuse, but there were times when I did physically abuse them, OK, but I chose incest to act out in. For me I guess that is the generational thing that I see.

Mr. LEHMAN. What I hear then is that you perceive something genetically, that it is possibly genetic that you have inherited and your father inherited, and that it is programmed into your central nervous system or whatever to this effect?

The WITNESS. OK, but there are other cases where children were molested by parents that were molested and don't grow up—

Mr. LEHMAN. Works both ways.

The WITNESS. And don't grow up to molest their own.

Mr. LEHMAN. So you go back to your original statement. It is something, from inception or whatever, which causes us, which I would think that some of the people here that are able to do anything on this would certainly look into this as a form of being able to gather some data on this problem.

I am not an anthropologist, but I have read some anthropology. If there is one thing that cuts across every culture in the world from the most primitive to the most modern, it is the anti-incestuous statement. That somehow or another the natural proclivity is not to incest. The natural proclivity in every society is, I guess, genetically programmed against incest. But there must be some exceptions.

The other question I would like to ask you, you mentioned that you came from a Christian home. I don't know what that has really to do with it. I happen to be Jewish, but I assume a Christian home means one that is in your interpretation one that probably was rather rigid, one that had no alcohol, did not use profanity, one that had a rather structured program of church observance, and had rather tight boundaries of behavior. You threw that in as sort of a throwaway line so to speak. But I look beyond the throwaway lines as to why you included that in, and whether you think, either consciously or subconsciously, this Christian home was a factor that kept you so tightly structured that you overreacted perhaps against some of the mores of what would be certainly Christian behavior.

The WITNESS. OK, I guess I brought that out to maybe help understand that there are no barriers to incest, OK? Even though there was, I say, a Christian home, we did have the rigid Christian beliefs, no drinking, no alcohol, no dirty language, so forth. There wasn't any family structure that I felt as a part of. So there is something in there that was missing.

During my life and adulthood I also got involved to the Christian belief to the point I was a Sunday School superintendent, Sunday School teacher, gospel singer. Yet I was acting out in an inappropriate manner. And so faith not necessarily teaches everything we need to know.

I never heard in the Christian areas of my own responsibility in my decisions: "Lord, I am having a problem with this," and pray about it, and that takes care of it. And that is not the answer. That is the way I see a crutch or something to where I can relinquish my adult responsibilities.

Mr. LEHMAN. Just to show you I am not in any way prejudiced, we actually had a rabbi once in my hometown in Alabama. We lost him because he followed a small child into a swimming pool. So you can be a very religious person in any religion and still not be able to control yourself when it comes to children.

The WITNESS. Right.

Mr. ANTHONY. Mr. Chairman, I have a couple of followup questions. As I understand your testimony, you say you are divorced. Your 18-year-old daughter lives not even with the natural mother, but with a friend of the natural mother?

The WITNESS. Yes.

Mr. ANTHONY. Your son is away from the home and is married?

The WITNESS. Yes.

Mr. ANTHONY. With or without children?

The WITNESS. Without so far.

Mr. ANTHONY. What I am curious about is whether or not at the present time there is a sufficient amount of regaining the self-esteem on your own part, a comprehensive understanding of what the problems are. You state that the problem is not curable but controllable. I would like to set up a hypothetical situation and then go back and be your therapist and ask you how you feel today.

The WITNESS. OK.

Mr. ANTHONY. Your 18-year-old daughter falls in love, gets married, and has children. You become a grandparent. Your son has children. You become a grandparent again. You are suddenly without the structure of the normalized Parents Anonymous or Parents United. You don't have that therapy session to attend. You state now for the record that although you didn't know, you now have found out that your grandfather and father were both child molesters. Do you feel you have established that inner control, and self-esteem? Has that been carried over into trust to Parents United and to both your son and your daughter to the extent that you feel like you could have a healthy, normal relationship with your grandchildren?

You could add to that. You appear to be a fairly young individual—possibly a new wife and a new family.

The WITNESS. OK, hypothetically I would rather not deal with that, but in real life my daughter is pregnant. The father, he has a lot of my old traits. She has decided not to marry.

There has been a trust factor to where she tells me she feels comfortable in me babysitting that child. For me that stimulates some fear, fear of my past doing, OK. But also it creates some—it creates some good feelings inside to realize that for myself I have changed a lot of my lifestyle, my attitudes. Looking at myself and checking and confronting myself and trying to help my therapist and other people confront me as to what they are seeing, is it real. For me when I finally draw my last breath on my deathbed and I can look back and I can reflect that I haven't molested and I haven't done things that were destructive, that I have been a productive person, I can say it was for real. If I take it away from my therapy or if I haven't, that is still my responsibility from my growth. I try to grow every day, from books I read, from movies, that I perceive something maybe the producer has put in there for someone's growth. I can become and continue to be a very productive person.

We have in Parents United what we call a sponsorship training which is special training once a month for people that have met certain criteria and growth. One of those exercises that we do is write down what you would like on your epitaph. For me, I want my children to write of their Dad as a loving Dad that was productive in my life.

There was a time during the judicial system in the process that I was very suicidal, and that I had my pistol in my mouth three times. And I see this is as a very low, irresponsible way of life. For some reason I didn't pull the trigger. For some reason something came inside of me and says, you have victimized your family all these years and here you are going to do the ultimate to them. Is that what you want your kids to remember you as? No. I love my kids. I want them to have good memories. No matter how much time I have on this Earth or to be with them, I will try to use it constructively and productively for them and for myself. And society.

I regret this screen, OK. There have been times when I was full face on T.V. and it was in an area and in a situation where they didn't make prints. Where it wouldn't be in the media and just to let the person know and the society what a perpetrator looks like. It is not the dirty old man that I remember being told about, with a trench coat and the bag of candy. It is somebody that you may be sitting next to in church, in here, or wherever, on the bus. It doesn't matter. We don't know that much about each other. My exwife, if she had known what was going to happen, she would have never stayed with me even though she was a victim, too.

Mr. ANTHONY. When you say she was a victim, you are saying she was molested as a child?

The WITNESS. She was molested by her cousin.

Mr. ANTHONY. Was she aware of the circumstances in the home prior to it being made public?

The WITNESS. No, I was too good at that. I had been trained and conditioned as a child growing up that I used to lie to my Mom because of the fear of what she might do if she found out and it seemed like she believed and it conditioned me into being a little better. I was secretive about what I did because I was ashamed of it because there was lack of self-control. There wasn't enough shame and enough motivation to stop it.

Mr. ANTHONY. What is the legal status of your case at the present time?

The WITNESS. I have been out from under the legal system for 2 years.

Mr. ANTHONY. No problem since?

The WITNESS. No.

Mr. ANTHONY. Gainfully employed?

The WITNESS. Yes. The legal system helped me realize the detriment that I had done. Parents United and therapy helped me realize the depth of my problem. The legal system implemented a lot of areas where I used to say that person runs a red light, he ought to go to jail, where I gave myself reasoning as to why I am late. It is OK for me, I have abided by the same rules everyone else does, and it has given me a motivation to put control in my life, whether it is speeding, going through a red light, or physically attacking someone. The laws I live under and the people I am involved with.

Mr. ANTHONY. Thank you.

I yield back.

Mr. LEHMAN. Thank you, and my hesitancy at the first part about the validity of this testimony has been certainly removed. At this point I really think that your testimony should have the same weight as any other testimony, and I think you have made a remarkable witness, that you are a sensitive human being and are a very bright human being, and you have made a real contribution to this committee and I thank you for being here.

The WITNESS. Thank you.

Mr. LEHMAN. Now, we will clear the room for about 5 minutes so our witness can go back to work. Then we will resume our last panel.

[A short recess was taken.]

Mr. LEHMAN. Panel number II is Vincent Fontana, Johanna Schuchert, Frederick Green, and J.M. Whitworth.

Please come to the witness table.

I am going to have to excuse myself for a few minutes. I am going to turn the hearing over until I am able to return, to Mr. Anthony. As with other witnesses, if you would summarize your statements, without objection, your full statements will be included in the hearing record.

The first witness will be Mr. Fontana.

STATEMENTS OF VINCENT FONTANA, M.D., MEDICAL DIRECTOR AND PEDIATRICIAN IN CHIEF, NEW YORK FOUNDLING HOSPITAL, CENTER FOR PARENT AND CHILD DEVELOPMENT, PROFESSOR OF CLINICAL PEDIATRICS, NEW YORK UNIVERSITY COLLEGE OF MEDICINE, CHAIRMAN OF MAYOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT OF THE CITY OF NEW YORK

Dr. FONTANA. I want to thank the chairman and committee for inviting me to testify at this hearing. I will read off my formal statement and then I will be happy to answer any questions that might be posed.

As a pediatrician who has been involved with the issues of child abuse and neglect for the last two decades, I can attest to the fact that we have had little help in dealing with the problems of child protection in this country. It has been difficult getting our legislatures and the community at large to understand and accept the reality of child maltreatment. The incidence of child abuse and neglect has been met with general disbelief as people sought ways of denying the existence of child maltreatment.

The process of awareness and acceptance has been a very slow process. Today in 1984, child maltreatment is recognized by the professionals as one of the most important social medical problems confronting our society. More than 1 million children a year are maltreated in the United States. Official national reports have increased by 125 percent between the years 1976 and 1982. In New York City alone, we average 55,000 reports of child abuse and neglect in any 1 year. For every child that is reported as being abused or neglected, I feel there are probably five or more children who are going unreported, undetected, and unprotected.

We are losing the battle against child abuse because of the governmental and community indifference. We feel that our endangered children are not endangered and we fail them—not by a lack of our knowledge but a failure to act on what we know.

Child maltreatment encompasses physical abuse, emotional abuse, sexual abuse, medical negligence, psychological neglect, and physical neglect. In all these cases, inadequate parenting is the major issue. Considering then the maltreatment of children in the context of these various signs of abuse and neglect, one can state that today in the 1980's child maltreatment is a major problem confronting a large number of parents caught in the web of a multiproblem family unit. It is estimated that between 84 and 97 percent of all parents subject their children to some type of punishment, physical or otherwise.

Child abuse and neglect is increasing at the rate of 15 percent every year throughout the United States in spite of all the positive advances and efforts that have been made in the field of recognition, prevention, and treatment. The problem of sexual abuse of children also continues to increase and the probability of a national incidence larger than the reported incidence of physical abuse of children is staggering.

The problem of children and families in crisis is rising. When children and families are subjected to a continuum of abuses and indifferences by society, we give rise to their fear, their neglect, their abuse, their isolation, and their despair. Complacence about this maltreatment of children is complacence about violence. If we do not recognize the one, we cannot conquer the other.

Within a troubled society, children in the welfare system who are seriously disadvantaged are particularly vulnerable to abuse and neglect. In the midst of family conflicts, economic and spiritual poverty, alcohol and drug abuse, a child's future growth and development is threatened. Unfortunately, the abuse and neglect among these children is unrelenting and life-threatening, with profound consequences to the child, family, and society.

Child abuse kills in three ways: the child, the family, and society. As a result, we are faced with the prospect of thousands of children growing up unhappy, maltreated, and deprived. The teenage delinquents, alcoholics, drug addicts, and prostitutes we see in our streets have for the most part been products of a multiproblem violent home in which they have suffered abuse and neglect. These are the children that assault, rob, murder, and commit suicide. These are the throwaway and the runaway children.

There are thousands of such troubled, emotionally damaged youth that are growing up finding it difficult to live with or without parents. These are the children that have been abandoned at home, have developed hostility and have declared open war on society and their parents. During these times, the lines of communication between parents and child are nonexistent, replaced by harsh words and unfair punishment which intensifies and perpetuates a vicious cycle of violence breeding violence within the family unit.

The cyclical nature of family violence results in violent behavior passed from one generation to another. It is definitely known that children learn violent behavior from their parents. The statistics show that children who grow up in a violent home are more likely to be violent than those reared in nonviolent homes. We cannot undo their existence and we cannot permit them to continue on their present course and tell ourselves we should have done something to prevent this unnecessary destruction of our children. There are remedies and there are ways of diminishing this national and social neglect of our children.

Although we need to continue our efforts to improve the quality of child protective services, we must also recognize the limitations inherent in reporting and reactive intervention. Our current approach to protecting children from abuse and neglect centers on reporting, which is dependent upon someone noticing that a child shows signs of possible maltreatment, and investigation, which is dependent upon someone reporting what they have noticed. Although official reports have increased enormously in the last decade, we are still not reaching all of the children who need help; the continued deaths of children is evidence of this failure.

Four thousand children die in the United States every year as a result of abuse and neglect. Two children a week die in New York City of abuse and neglect. We must confront the fact that even the most perfect reporting and investigation system possible may never be able to reach all of the children who need protection. What we are seeing is the upper part of a submerged iceberg. Some children will never be detected in time because parents can hide the reality of child maltreatment. Parents can learn how to avoid detection and the system through experience with it. This happens in all systems, and there is no reason to doubt that it is happening with the child protection system. But this should not make us helpless. There are ways and a wealth of knowledge and experience that can and should be put to work.

In the field of child maltreatment, treatment and preventive programs based on our current understanding of the psychodynamics of this pediatric problem have been found to be effective. The need for these treatment programs is growing and with this growth, there is also the urgent need of a professional and community concerned awareness that child abuse is everybody's business. The establishment of a systemic process for identifying all "high risk" families and children from birth in coordination with area hospitals, pediatric groups, public health, and family practitioners provides a vital link for early identification and primary prevention.

Another way is the encouragement of parental self-help. The key to true prevention of child abuse and neglect is to encourage parents to seek help voluntarily before a child is harmed or killed. Experience with various experimental treatment programs has shown that parents will seek help if properly encouraged and offered genuine nonpunitive help. This approach builds on the internal motivation many abusing parents have to find a way out from the hurtful cycle of maltreatment. If these parents are reached, we can begin to close the gap in the protection obtained through the reporting-investigating system currently in place.

Parents who are not reported can, in effect, learn to report themselves for help if the fear of punishment and retribution is lessened through supportive help designed to maintain the family.

Parents under stress which may lead to abuse frequently seek help indirectly to avoid the stigma associated with abusing and neglecting parents. They ask for help without disclosing the true nature of their problem or their anxiety for the safety of their children. They seek help silently because they care about their children, they know a cry of pain when they hear it, they are afraid of their own impulses to harm their children, and they dimly recognize that they need outside help.

Such parents frequently turn to hospitals. Their request for help is hidden in a seemingly meaningless action. They take a healthy child to a hospital claiming the child is sick and should be admitted for treatment, but the examining physician finds no health problems to warrant hospitalization. In the past, such parents would leave the child at a hospital, disappear for a few days and then return to pick up the child. In effect, these parents are asking the hospital to take the child off their hands during a crisis because they fear they may harm the child. Unfortunately, these pleas for help are frequently not understood, or if they are, there is no procedure that allows the sought help to be given.

Indeed, under the hospital utilization procedures in effect to control medicaid expenditures, admitting such a child may no longer be possible. Hospitals in the past would retain patients, especially children, for social rather than medical reasons, but this practice is now discouraged if not forbidden. When a child is deemed to have been kept in a hospital without a medical cause, medicaid reimbursement is either denied or the daily rate is reduced. Hospitals, understandably, see themselves as losing money in such circumstances. Efforts must be made to find solutions to this hospital reimbursement problem which impedes lifesaving rescue operations for children in jeopardy.

In October 1981, the mayor's task force of the city of New York, proposed to Mayor Koch the establishment of the "islands of safety" program to prevent child abuse and neglect. This would be an operation which would provide safety for the child and a "bailout" for the parents. This program consisted of three components: A series of crisis nurseries located in various hospitals throughout the city; volunteer crisis information and referral centers located in the schools; and a citywide mass media campaign to encourage parents to seek help voluntarily before abuse occurs or worsens.

Mayor Koch responded by establishing one pilot crisis nursery, located at the New York Foundling Hospital, and five school based programs, located in one school district in each of the boroughs of the city. The major picked the site for the demonstration crisis nursery after the Health and Hospitals Corporation raised objections to instituting nurseries in the regular acute care hospitals under its jurisdiction. The type of reimbursement for utilization of hospital beds was also questioned.

The pilot crisis nursery at the New York Foundling Hospital was inaugurated, by the mayor and the city council president, in early April 1982. The program provides a 24-hour capability of offering short-term relief to highly stressed parents in crisis situations and links the parents to larger systems of social programs for concrete services and long term counseling within their communities. The program is now 2 years old and has proven that parents will use its services if they know about them. Six hundred and four children were admitted to the crisis nursery from March 1982 to January 1984. An additional 251 children received services but were not admitted to the nursery. The crisis nursery parent helpline—and we use the words "parent helpline" because using the words child abuse obviously is not going to get anyone to call—and so we have instituted the term "parent helpline" and we have received over 5,456 calls since its inception. A total of 855 children and 477 families have been served during this short period.

The basic operating assumption of the crisis nursery is the expectation that parents in stress or crisis may need immediate relief to prevent child abuse or neglect. This assumption derives from the stress model of child maltreatment, which explains the causation of many child abuse and neglect cases as a result of parental frustration, extreme tension, depression, and even despair. In some cases, the stress itself may stem from issues that are not directly related to the child. The presenting problems of the parents who have turned to the crisis nursery for help are in accord with this basic program assumption. Many of the parents that have come voluntarily to the crisis nursery were not known to the network of child protection within the city.

Slightly more than 34 percent of the cases involved parental fears of being unable to maintain self-control toward the child. Slightly more than one-fourth of the parents experienced difficulty in controlling a child; most of these parents were trying to cope with hyperactive or acting out children, including several whose children were setting fires. In almost one-fifth of the cases the parent was distressed over spanking or hitting a child because such a response was atypical or stronger then customary.

Perhaps as part of a developing national problem, approximately one-fifth of the cases involved families who were undomiciled, a number of whose parents had refused to go to a shelter because of the low reputation of actual conditions in the shelter. For admission, into the nursery there had to be an indication that a child could be endangered because of parental stress or crisis.

Various forms of interpersonal conflict were among the presenting problems of the families who came to the crisis nursery. In almost one-fifth of the cases, family violence was a problem. Most of this violence was between the parents or a parent and a boy friend. In several cases, however, it was between a parent and a grandparent. In another large group of cases there was a significant family conflict or fighting that had not, at least yet, reached the level of overt violence.

Although the crisis nursery was designed to operate with an awareness that parents can be deterred from seeking help because of fears that their children would be taken away from them, we were surprised to discover that 15 percent of the parents came to the crisis nursery because they were actively seeking to have their children placed. Most had applied for placement of their child but had been rejected.

Most of the children served by the program, however were not placed. A placement occurred in only 28 percent of the cases. About three-fourths of the cases received services other than placement. Among the most frequent referrals were counseling or therapy; day care; rehousing; welfare; shelter or temporary living arrangements; parent education programs; homemaker services; and employment or vocational services.

The experience of the crisis nursery during its 2 years in operation has demonstrated that the basic concept for the nursery as an "island of safety" is a practical and realistic approach to the prevention of child maltreatment, and that it can work in a large city such as New York. It has proven that parents can be encouraged to seek help on their own, that parents will use such a program when they know about it, and that meaningful help can be provided to them in a nonthreatening caring environment.

Another statistic is that 75 percent of the families that have been referred to a community program have followed through after having been followed for a period of 1 year.

Our experience in New York City, coupled with the experiences of other programs throughout the United States, have demonstrated that child abuse can be prevented, that parents can be reached before seriously harming their children. We have laid the foundation for developing a new approach to protecting children from abuse and neglect.

All programs that promote parental self-help, including crisis nurseries, drop in centers, crisis intervention services, and Parents Anonymous, can help us reach parents who are not being identified by the existing reporting and investigation system. The parent self-help approach is the best means we have of closing the gaps in this system, and reaching those parents that are practicing child abuse behind closed doors and shuttered windows, parents who know a cry of pain when they hear it. They hate themselves for what they are doing, they want help but are afraid to ask for it because of the stigma of child abuse and the fear of having their children removed from them.

Crisis nurseries and islands of safety are approaches which can fill a crying need for thousands of children and families entrapped in the web of child maltreatment. We have found ways of preventing child abuse and neglect. The issue before us is putting dollars into developing and supporting these effective programs. Programs such as crisis nursery concept offers maximum opportunity at minimum expense to combat the increasing problem of child abuse and needless death of infant children.

The bottom line I believe is whether we truly care about making things better in this country for children and families or whether we will continue to brag about being a child oriented society while providing less and less dollars for our children's health and welfare.

I have great concern about an administration with double standards, one that professes strong commitment to the rights of life and handicapped children while cutting expenses for their treatment services. In addition, I also have great concern about ignoring the rights of life of the 4,000 or more normal children that die of abuse or neglect in this country every year while not providing the necessary amounts of money to protect them and give them the type of future that we should be giving to this country's most important natural resource, namely our children.

Thank you.

[Fontana, V.J., Donovan, D. and Wong, R.J. The "Maltreatment Syndrome" in children. New England Journal of Medicine, 1963, 269: 1389–1394.]

[Prepared statement of Vincent J. Fontana follows:]

PREPARED STATEMENT OF VINCENT J. FONTANA, M.D., MEDICAL DIRECTOR AND PEDIATRICIAN-IN-CHIEF, NEW YORK FOUNDLING HOSPITAL, CENTER FOR PARENT AND CHILD DEVELOPMENT, PROFESSOR OF CLINICAL PEDIATRICS, NEW YORK UNIVERSITY COLLEGE OF MEDICINE, CHAIRMAN OF MAYOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT OF THE CITY OF NEW YORK

As a pediatrician who has been involved with the issues of child abuse and neglect for the last two decades, I can attest to the fact that we have had little help in dealing with the problems of child protection in this country. It has been difficult getting our legislatures, and the community-at-large to understand and accept the reality of child maltreatment. The incidence of child abuse and neglect has been met with general disbelief-as people sought ways of denying the existence of child maltreatment. The process of awareness and acceptance has been a very slow process. Today in 1984, child maltreatment is recognized by the professionals as one of the most important social-medical problems confronting our society. More than one million children a year are maltreated in the United States. In New York City alone, special services for children projects that more than 55,000 children will be reported as abused or neglected in 1984.

Child maltreatment is not a new phenomenon. It has existed since the beginning of time. However, it wasn't until 1962 that the topic of child abuse actually gained medical attention when Dr. C. Henry Kempe and his associates in an article in the Journal of the American Medical Association coined the term "battered-child syndrome" and proposed that such abuse was a frequent but unsuspected cause of permanent injury or death to these children. I read

Dr. Kempe's paper on the battered child and was appalled by the content. In making rounds at the New York Foundling Hospital, it soon became apparent that although some had been brought in after having been battered, a great majority showed signs of insidious neglect, failure to thrive, malnutrition, poor skin hygiene, irritability, repressive personality, retardation syndromes and sexual abuse. In coming to grips with the whole picture of neglect and abuse of children, I was able to see a situation varying from the deprivation of food and clothing, shelter and parental love to instances in which children were physically abused and mistreated by an adult with resulting physical trauma and oftentimes death. In 1963, I published a paper, "The Maltreatment Syndrome in Children" (see attachment 1) in the New England Journal of Medicine and proposed an all-encompassing description of child abuse and neglect and indicated that the battered-child phenomenon is in fact the last phase of the maltreatment spectrum.

Child maltreatment, therefore, as defined today spans a wide spectrum of commissions and omissions by parents and guardians. We encounter emotional or verbal abuse, physical and sexual abuse. The broad term "neglect" has come to include emotional neglect or maternal deprivation, physical neglect, malnutrition, inappropirate clothing, lack of supervisions, medical neglect, educational neglect and abandonment.

In all these cases, inadequate parenting is the major issue. Considering then the maltreatment of children in the context of these various signs of abuse and neglect, one can state that today in the 1980's child maltreatment is a major problem confronting a large number of parents caught in the web of a multiproblem family unit. It is estimated that between 84 and 97 percent of all parents subject their children to some type of punishment, physical or otherwise.

Child abuse and neglect is increasing at the rate of 15% every year throughout the United States in spite of all the positive advances and efforts that have been made in the field of recognition, prevention and treatment. The problem of sexual abuse of children also continues to increase and the probability of a national incidence larger than the reported incidence of physical abuse of children is staggering. The problem of children and families in crisis is rising. When children and families are subjected to a continuum of abuses and indifferences by society, we give rise to their fear, their neglect, their abuse, their isolation and their despair. Complacence about this maltreatment of children is complacence about violence. If we do not recognize the one we cannot conquer the other.

Within a troubled society, children in the welfare system who are seriously disadvantaged are particularly vulnerable to abuse and neglect. In the midst of family conflicts, economic and spiritual poverty, alcohol and drug abuse, a child's future growth and development is threatened. Unfortunately, the abuse and neglect among these children is unrelenting and life-threatening with profound consequences to the child, family and society that are both immediate and long term. As a result we are faced with the prospect of thousands of children growing up unhappy, maltreated and deprived. The teen-age delinquents, alcoholics, drug addicts and prostitutes we see in our streets, have for the most part been products of a multiproblem violent home in which they have suffered abuse and neglect. These are the children that assult, rob, murder and commit suicide. These are the throwaway and the runaway children. There are thousands of such troubled, emotionally damaged youth that are growing up finding it difficult to live with or without parents. These are the children that have been abandoned at home, have developed hostility and have declared open war on society and their parents. During these times, the lines of communication between parents and child are non-existent replaced by harsh words and unfair punishment which intensifies and perpetuates a vicious cycle of violence breeding within the family unit. The cyclical nature of family violence results in violent behavior passed from one generation to another. Children learn violent behavior from their parents - the statistics show that children who grow up in violent homes are more likely to be violent than those reared in non-violent homes. We cannot undo their existence and we cannot permit them to continue on their present course and tell ourselves we should have done something to prevent this unnecessary destruction of our children. There are remedies and there are ways of diminishing this national and social neglect of our children.

Although we need to continue our efforts to improve the quality of child protective services, we must also recognize the limitations inherent in reporting and reactive intervention. Our current approach to protecting children from abuse and neglect centers on reporting, which is dependent upon someone noticing that a child shows signs of possible maltreatment, and investigation, which is dependent upon someone reporting what they have noticed. Although official reports have increased enormously in the last decade, we are still not reaching all of the children who need help; the continued deaths of children is evidence of this failure.

We must confront the fact that even the most perfect reporting and investigati system possible may never be able to reach all of the children who need protection. Some children will never be detected in time because parents can hide the reality of child maltreatment. Parents can learn how to avoid detection and the system through experience with it; this happens in all systems, and there is no reason to doubt that it is happening with the child protection system. But this does not make us helpless. There are ways.

In the field of child maltreatment, treatment and preventive programs based on our current understanding of the psycho-dynamics of this pediatric problem have been found to be effective. The need for these treatment programs is growing and with this growth there is also the urgent need of a professional and community concerned awareness that child abuse is everybody's business. The establishment of a systemic process for identifying all "high rish" families and children from birth in coordination with area hospitals, pediatric groups, public health and family practitioners provides a vital link for early identification and primary prevention.

Another way is the encouragement of parental self-help. The key to true prevention of child abuse and neglect is to encourage parents to seek help voluntarily before a child is harmed irrepairable or killed. Experience with various experimental treatment programs has shown that parents will seek help if properly encouraged and offered genuine non-punitive help. This approach builds on the internal motivation many abusing parents have to find a way out from the hurtful cycle of maltreatment. If these parents are reached, we can begin to close the gap in the protection obtained through the reporting-investigating system currently in place. Parents who are not reported can, in effect, learn to report themselves for help -- if the fear of punishment and retribution is lessened through supportive help designed to maintain the family.

Parents under stress which may lead to abuse frequently seek help indirectly to avoid the stigma associated with abusing and neglecting parents. They ask for help without disclosing the true nature of their problem or their anxiety for the safety of their children. They seek help silently because they care about their children, they know a cry of pain when they hear it, they are afraid of their own impulses to harm their children, and they dimly recognize that they need outside help.

Such parents frequently turn to hospitals. Their request for help is hidden in a seemingly meaningless action. They take a healthy child to a hospital claiming the child is sick and should be admitted for treatment, but the examining physician finds no health problems to warrant hospitalization. In the past, such parents would leave the child at a hospital, disappear for a few days, and then return to pick up the child. In effect, these parents are asking the hospital to take the child off their hands during a crisis because they fear they may harm the child. Unfortunately, these pleas for help are frequently not understood, or, if they are, there is no procedure that allows the sought help to be given.

Indeed, under the hospital utilization procedures in effect to control Medicaid expenditures, admitting such a child may no longer be possible. Hospital used to retain patients, especially children, for "social" rather than medical reasons, but this practice is now discouraged if not forbidden. When a child is deemed to have been kept in a hospital without a medical cause, Medicaid reimbursement is either denied or the daily rate is reduced from the hospital rate of about $200 per day to a boarder rate of about $40 per day. Hospitals, understandably, see themselves as "losing" money in such circumstances. Efforts must be made to find solutions to this hospital reimbursement problem which impedes life saving rescue operations for children in jeopardy.

New York City's Islands of Safety Program

In October 1981, the Mayor's Task Force proposed to Mayor Koch the establishment of an "Islands of Safety" program to prevent child abuse and neglect. This program consisted of three components:

- a series of crisis nurseries located in various hospitals throughout the City
- volunteer crisis information and referral centers located in the schools
- a city-wide mass media campaign to encourage parents to seek help voluntarily before abuse occurs or worsens

Mayor Koch responded by establishing one pilot crisis nursery, located at the New York Foundling Hospital, and five school-based programs, located in one school district in each of the boroughs of the City. The Mayor picked the site for the demonstration crisis nursery after the Health and Hospitals Corporation raised objections to instituting nurseries in the regular acute care hospitals under its jurisdiction. The type of reimbursement for the utilization of hospital beds was also questioned.

New York Foundling Crisis Nursery - "Island of Safety"

The pilot crisis nursery at the New York Foundling Hospiatl was inaugurated, by the Mayor and the City Council President, in early April 1982. The program is now 2 years old and has proven that parents will use its services if they know about them. 367 children were admitted to the Crisis Nursery during its first year in operation; an additional 78 children received services but were not admitted. The Crisis Nursery's Parent Helpline has received over 4,000 calls since its inception.

A basic operating assumption of the Crisis Nursery is the expectation that parents in stress or crisis may need relief to prevent child abuse or neglect. This assumption derives from the "stress model" of child maltreatment, which explains the causation of many child abuse and neglect cases as a result of parental frustration, extreme tension, depression and even despair. In some cases, the stress itself may stem from issues that are not directly related to the child. The presenting problems of the parents who have turned to the Crisis Nursery for help are in accord with this basic program assumption.

Slightly more than 34% of the cases involved parental fears of being unable to maintain self-control towards the child. Slightly more than one-fourth (26%) of the parents experienced difficulty in controlling a child; most of these parents were trying to cope with hyperactive or acting-out children, including several whose children were setting fires. In almost one fifth (16%) of the cases, the parent was distressed over spanking or hitting a child because such a response was atypical or stronger than customary.

Perhaps as part of a developing national problem, approximately one fifth (18%) of the cases involved families who were undomiciled, a number of whose parents had refused to go to a shelter because of the low reputation or actual conditions in the shelte. . For admission, there had to be an indication that a child could be endangered because of parental stress or crisis.

Various forms of inter-personal conflict were among the presenting problems of the families who came to the Crisis Nursery. In almost one fifth (18%) of the cases, family violence was a problem. Most of this violence was between the parents or a parent and a boyfriend. In several cases, however, it was between a parent and a grand-parent. In another large group of cases (23%), there was a significant family conflict or fighting that had not, at least yet, reached the level of overt violence.

Although the Crisis Nursery was designed to operate with an awareness that parents may be deterred from seeking help because of fears that their children would be taken away from them, we were surprised to discover that 15% of the parents came to the Crisis Nursery because they were actively seeking to have their children placed. Most had applied for placement but had been rejected.

Most of the children served by the program however, were not placed. A placement occurred in only 28% of the cases. About three fourths of the cases received services other than placement. Among the most frequent referrals were: counselling or therapy (51%); day care (20%); rehousing (16%); welfare (13%); shelter or temporary living arrangements (11%); parent education programs (14%); homemaker services (8%); and employment or vocational services (4%).

The experience of the Crisis Nursery, during its two years in operation has demonstrated that the basic concept of the nursery as an "Island of Safety" is a practical and realistic approach to the prevention of child maltreatment, and that it can even work in a large city such as New York. It has proven that parents can be encouraged to seek help on their own, that parents will use such a program when they know about it, and that meaningful help can be provided to them in a non-threatening caring environemnt.

Conclusion

Our experience in New York City, coupled with the experiences of other programs throughout the United States, have demonstrated that child abuse can be prevented, that parents can be reached before seriously harming their children. We have laid the foundation for developing a new approach to protecting children from abuse and neglect. All programs that promote parental self-help, including crisis nurseries, drop-in-centers,crisis intervention services, and Parents Anonymous, can help us reach parents who are not being identified by the existing reporting and investigation system. The parent self-help approach is the best means we have of closing the gaps in this system, and reaching those parents that are practicing child abuse behind closed doors and shuttered windows - parents who know a cry of pain when they hear it. They hate themselves for what they are doing, they want help but are afraid to ask for it because of the stigma of child abuse and the fear of having their children removed from them. Crisis Nurseries and Islands of Safety are approaches which can fill a crying need for thousands of children and families entrapped in the web of child maltreatment.

CRISIS NURSERIES - A PREVENTIVE APPROACH TO CHILD MALTREATMENT

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Reports of child abuse and neglect have risen dramatically throughout the United States in the past decade due in part to a greater professional and public awareness of the problem. There are other factors that must be considered in the escalation of child abuse, namely unemployment, the state of the economy and the demise of the extended family. The despair and frustration experienced by a parent who is unemployed or having fiscal problems can result in child maltreatment. The relationship between poverty, unemployment and greater risk for child maltreatment is an important consideration since many parents are finding it increasingly more difficult to cope with the demands and responsibilities of child rearing. In New York City between July 1981 and June 1982 alone, reports increased by 26% as compared with a comparable period the year before. 46,000 city children were involved in the child abuse and neglect reports to the State's Central Registry. The annual New York State total has more than doubled from 29,912 reports in 1974 to 64,421 in 1981.

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Most abusive parents are overwhelmed by the demands of parenting due to a variety of situational and personal stresses. In general, abusive parents have very few lifelines, suffering from social isolation, low self esteem, depression and poor self control. During a time of diminished capacity to cope, especially when under situational stresses such as financial worries, alcoholism, drug addiction, teen-age pregnancies, illness, death of a loved one, divorce or separation, children are at the greatest risk for serious abuse or neglect at the hands of their parents.

In response to these realities, the concept of crisis nurseries as "islands of safety" was conceived and developed. The crisis nursery can serve as an "Island of Safety" for the child and parents by providing a frustrated and distraught parent a "cooling off" period and human supportive services that can help prevent future child maltreatment. The concept of a crisis nursery -- "Island of Safety" -- provides, therefore, a safe environment for the child and a non-threatening resource for the troubled parent. It is meant for the many parents who do not want to harm their children but may because they are on the brink of violent acting out behavior. A program of this type seeks to offer parents in crisis an alternative to child abuse or neglect and a path to finding help.

In November of 1981, the Human Resources Administration of the City of New York responded to the Mayor's Task Force on Child Abuse's proposal for establishing an "Island of Safety" program in New York City.

A pilot crisis nursery was established at the New York Foundling Hospital Center for Parent and Child Development maintaining a twenty-four hour capability of responding to calls for assistance to distressed parents. By offering crisis intervention to highly stressed parents and linking the parent to the larger system of social services within the community, the potential for abuse/neglect is immediately diminished. It may not be the answer to every case of child abuse or neglect but it has already proven to be helpful to those parents and children who have been afraid to ask for help because of the stigma of child abuse and the fear of having their child removed from their care.

The populations served by the crisis nursery are parents or bonafide caretakers of children six years of age or under who are at risk of being abused or neglected. The services provided for the children admitted to the crisis nursery include: physical examination and routine medical care; shelter and sleeping accomodations; meals; supervised play periods; behavioral assessment by the child care staff; and protective custody of a child if warranted. For the parents: temporary relief or a "cooling off" period from their child care responsibilities; psycho-social assessment and evaluation; counseling; concrete assistance; referral supportive services; and emergency assistance if necessary for transportation, food and shelter. The program is more than just a nursery where parents can leave their children for one or two days, but also offers a range of supportive community services to the parents even if the children are not kept overnight. Children are admitted overnight only when professional judgment indicates that their admission is necessary for their safety.

The crisis nursery is a residential care facility which provides short-term, 24 to 72 hours, care to children who are potential victims of abuse or neglect. The services of the New York Foundling's crisis nursery are available to parents of children 6 years or younger throughout the five boroughs of the city, exceptions being made to the age limitation based on census and clinical judgment. A parent helpline number publicized by means of a public awareness campaign indicated the availability of an "Island of Safety" for troubled parents. Because abusive and neglectful parents frequently do not have transportation, every effort is made by staff to arrange for parents' arrival to the crisis nursery in a convenient and easy manner. The nursery accepts referrals from all private and public agencies and from the parents themselves.

It is important for the success of a crisis nursery that a working relationship be developed with the local child protective units in order to coordinate and expedite the necessary supportive services for the parent and provide protection of the child whenever necessary. It is essential that the reporting and investigation by social services be done in such a way that the parents view this intervention as help and not an intrusion in an effort to remove the child from the family unit.

RESULTS

During the first 12 months 367 children from 217 families were admitted to the crisis nursery. An additional 78 children from 44 families received in-person services without being admitted to the nursery. During this time, the parent helpline received 2,997 calls. The volume of service activity on cases receiving program services include: (1) 626 in-person interviews or counseling sessions with parents and other involved relatives; (2) 1,924 telephone conversations with parents and other family members; (3) 1,015 collateral telephone conversations with various agencies; and (4) 945 calls to or from components of the New York City Special Services for Children Agency,

176 case records on families involving 340 children that received services from the Crisis Nursery at the New York Foundling Hospital between March 29, 1982 and March 31, 1983 were received and the data is

highly representative of the cases that have been served by the Crisis Nursery. The tabulations are based on hand counts and consist of frequency distributions. No computer facilities were available to perform more elaborate analysis of the data collected. The report is meant to be a preliminary evaluation of the type of families that were serviced in the Crisis Nursery during the first year of its operation.

The age of the mothers known to the Crisis Nursery ranged from 15 to 45 years old, with an average age of 27.3. Almost 11% of the mothers were under 20 years old, and 15% were over 35 years old. Although the teenage mother is generally considered to be a higher risk for possible child maltreatment, about two thirds of the mothers who came to the Crisis Nursery were between 20 and 30 years old.

As can be expected, the age of the mothers at the time of the birth of their first child, as reported to the Crisis Nursery, is lower than the average age at time of contact with the nursery. The average age at which the mothers gave birth to the first child, they informed the Crisis Nursery, is 21. Almost half of these mothers (46%) first gave birth during their teenage years. Approximately 8% were between 13 and 15 and 38% were between 16 and 19 years old. Seven percent were 30 or older when they gave birth to their first child.

Although 15% of the case records did not include data on the number of fathers, information available indicated that 6% of the cases involved three fathers; 57% involved only one father, and another 21% involved two fathers.

It is possible, of course, that the mothers did not accurately report the true number of fathers of their children, but there is little reason to accept this explanation because of the sensitive and personal nature of other information they did report to the staff. The important issue is not the total number of fathers but the presence or absence of the fathers, which is a measure of the extent to which the mothers are bearing the full responsibility of child care.

In over three fourths of the cases (77.3%), no father was in the home. The father was in the home in only 16% of the cases. This means, of course, that the mothers often bear the full weight of the burden of raising their children. This is reinforced by the fact that more than 80% of the mothers were not living with other relatives or friends and even among those who were, there was frequently conflict; thus, the living arrangements were not a source of support and most of the mothers were living in social isolation. In 6% of the cases, the records were not clear about whether or not a father was in the home.

The average number of children per family was 1.9 which is about the same as the average number of children in families reported for suspected child abuse or neglect (1.7 in New York City in 1980). Almost half of the families (44%) had one child and almost another third (32%) had two children. Only 2.4% of the families had six or more children. One family was the classically large family of nine children.

A total of 340 children in 176 families were seen of which 254 or 75% were admitted to the Crisis Nursery. Approximately one fourth (24%) of the families had three or more children when interviewed. The smaller size of these families, as well as the families reported for suspected child abuse and neglect, may well reflect the general decreasing size of

American families and that large families are not necessarily more likely to be at risk for child maltreatment.

Over ninety percent (93%) of the mothers who came to the Crisis Nursery were from minority groups: black (57%), hispanic (32%) and one oriental mother. Only 7% were white, including Russian and Eastern European. This data was not obtained in seven cases that consisted of an anonymous telephone contact. The ethnicity of the fathers does not necessarily correspond to the mother's. For example, the father of the oriental mother's child was hispanic but this data was less frequently known because of the limited contact with most of the fathers.

The majority of the families (59%) are on welfare; two of these families were receiving public assistance in another state at the time of their contact with the Crisis Nursery. Another 5% of the families had recently been cut off welfare and 3.9% were trying to get on it. Ten percent were receiving Supplemental Security Income, disability or Social Security benefits or unemployment insurance. Twenty-three percent were not on welfare or receiving other benefits and in 1% of the cases, the mothers were evasive about their income. This data was not available on 3% of the cases.

Over one fourth of the families (27%) had related a history of substance abuse, involving the parents or grandparents. Hard drugs accounted for 13% of this total while alcohol accounted for 9% of this total. Almost five percent involved both drug and alcohol abuse.

It is entirely possible that these data underestimate the history of drug abuse within the families that came to the Crisis Nursery. Parents may have been reluctant to discuss possible criminal violations that are current; most of the reported drug addiction was described as in the past or as involving an absent parent.

Almost one third (30%) of the parents who came to the Crisis Nursery indicated that they had been abused or neglected as children. It is possible that a long-term treatment relationship, rather than the crisis intervention service of the nursery, might reveal that more of the parents were maltreated as children. In at least 8% of the cases one parent had been placed as a child.

Almost half of the 176 families came to the Crisis Nursery through two ways: 23% were parents who came to the New York Foundling because of the Foundling's general reputation; either they or a friend had heard of it or had previous contact with the Foundling Hospital. 18% responded to posters that the Human Resources Administration designed and placed in Income Maintenance Centers, Medicaid Offices, Day Care Centers, and Public Housing lobbies. Another 18% of the parents were referred by other agencies or hospitals. Thirteen percent were referred by the public child protective welfare agency (Special Services for Children), and 6% were referred through a centralized parent helpline established by HRA during the second six months of the program's existence. Four percent responded to special notices mailed with public assistance checks, and another 4% came on the recommendation of other Crisis Nursery clients. Eleven percent heard of the program because of radio and television programs or articles in newspapers and magazines.

A basic operating assumption of the Crisis Nursery is the expectation that parents in stress or crisis may need relief to prevent child abuse or neglect. This assumption derives from the "stress model" of child maltreatment, which explains the causation of many child abuse and neglect cases as a result of frustration, extreme tension and even despair that is displaced from the crisis situation to the child. In some cases, the stress itself may stem from issues that are not directly related to the child. The presenting problems of the parents who have turned to the Crisis Nursery for help are in accordance with this basis program assumption.

Most of the parents who have come to the Crisis Nursery had more than one presenting problem. For them to receive help from the Crisis Nursery, however, the initial assessment must disclose a connection between the presenting problem and the safety or well-being of a child in the care of the parent. These are the problems that were noted at the time of the initial assessment and opening of a case. The customary experience in social services, that additional problems surface later on, is also true for the Crisis Nursery.

Slightly more than one-third of the cases (34%) included parental fears of being unable to maintain self-control toward the child. Slightly more than one-fourth (26%) of the parents reported difficulty in controlling a child's behavior. Most of these parents were attempting to cope with hyperactive or acting out children, including several whose children were setting fires. In only one of these cases was it clear to the staff that the child was not a behavior problem, but that the parent had a highly distorted view of the child's behavior. In almost one-fifth (16%) of the cases, the parent verbalized distress over spanking or hitting a child because such a response was atypical or much stronger than customary disciplinary measures.

Approximately one-fifth of the cases (18%) involved families that were undomiciled a number of whose parents had refused to go to a shelter because of the reputation or actual conditions in the shelter. The mere fact of undomocility was not sufficient to admit a child into the crisis nursery. For admission, there had to be an indication that the child could be endangered because of parental stress or crisis. The data presented in Table 14 concern only cases that were accepted or opened for services. Other housing problems included impending eviction which was reported in 22% of the cases.

Various forms of inter-personal conflict were among the presenting problems of the families who have come to the Crisis Nursery. In almost one-fifth (18%) of the cases, family violence was a current problem. Most of this violence involved the parents or a mother and a boyfriend. In several cases, however, it was between a parent and a grandparent. In one such case, the maternal grandmother had pulled a knife on the mother during a heated argument and threatened her family. In another large group of cases (23%), there was significant family conflict that had not reached the level of overt violence.

Other presenting problems that occurred in a significant proportion of the cases were: psychiatric problems including institutionalization (7%); recent desertion or separation of a parent (12%); disputes with an Income Maintenance Center, usually over the closing of a case for failure to keep appointments (16%); parents seeking placement of their children (15%); health problems of a parent, child or close relative (15%); depression (6%). About 15% of the children had overt signs of being abused or neglected when seen during the intake interview.

The Crisis Nursery is designed and operated with an awareness that parents may be deterred from seeking help because of fears that their children would be taken away from them. Thus it was interesting to find that almost 15% of the parents came to the Crisis Nursery because they were actively seeking to have their children placed. Most had applied for placement of their children into foster care but had been rejected. A number reported that they were told by the City's Special Services for Children Agency workers that their children could not be placed because they had not been abused or neglected. This phenomena may reflect the implementation of the Child Welfare Reform Act which seeks to keep children out of placement.

254 children from the 176 families whose case records were read were admitted to the Crisis Nursery for at least one day. This represents 75% of all the children living with the parents in these cases. Thus, in a number of cases, all of the children in the family were not admitted. Sometimes, only one child was, a possible reflection of the accuracy of the "target child" concept in the battered child syndrome. The average number of children admitted per case was slightly more than 1.4 per case. Forty-one children were admitted during a repeat crisis episode.

Almost two-thirds (63%) of the cases the Crisis Nursery served were not reported to the State Central Register for suspected child abuse or neglect as a result of involvement with the program. More than one-third (37%), however, were reported by the crisis nursery to the Central Registry.

Most children who were reported as abused or neglected were not placed in foster care; approximately 20% of the children that were indicated cases of abuse or neglect were placed. Thirty-three percent of the children discharged from the Crisis Nursery after an initial or repeat crisis episode were placed in foster care; this includes both children reported as well as children whose parents were seeking placement. At least seven of the children, or 15.5% of the placed children were put in the care of other relatives, including a different parent. The placement rate of the children per family is 28%.

Three-fourths of the cases known to the Crisis Nursery, and included in the study sample, received services other than placement. Among the most frequent referrals were: counseling or therapy (51%); day care (20%); rehousing (16%); welfare (13%); shelter or temporary living arrangements (11%); parent education programs (14%); homemaker services (8%); employment or vocational services (4%).

Follow-up Results

The authors attempted to obtain follow-up information on each of the families which has received any type of service from the program. In 90% of the cases, such information was available from the parents or an agency to which they were referred. These follow-up inquires were performed at thirty and sixty day intervals following the program's last service contact with the family. In slightly more than half the cases, the services to which they were referred had been provided and completed. In about one-fourth of the cases, the family had not followed through on the referrals or proved to be "unamenable" to them. In seven percent of the cases, the family was either on a waiting list or an initial appointment was scheduled. Five percent were partially engaged in the referral services.

In 49 of the 176 cases, one or more children in the family were placed in foster care through the Crisis Nursery. Follow-up data was available in 48 of these cases. In 33 (or 69%), the placement was still in effect.

In 13 (or 27%) the placement had been terminated through return of the child to the parents or other relatives. In one case, a child was on a trial discharge to the parents, and in two cases, arrangements were being made for the children's adoption.

SUMMARY

The Crisis Nursery consists of three major program elements; a parent helpline that is available 24 hours a day for emergency contact with the staff; the housing facility which is designed to accommodate up to 10 children who are admitted to the nursery and counseling supportive services for families whose children are not admitted.

Mr. ANTHONY. Thank you.

I think with Mr. Bliley's permission, what we will do is take testimony from all four members of the panel, then we will direct our questions to the panel as a whole.

STATEMENT OF JOHANNA SCHUCHERT, EXECUTIVE DIRECTOR, PARENTS ANONYMOUS OF VIRGINIA, RICHMOND

Ms. SCHUCHERT. Mr. Chairman, members of the committee, my name is Johanna Schuchert. I am executive director of Parents Anonymous in Virginia. As you have heard from other members of this panel child abuse and neglect is a major national concern which we must come to terms with if our society is to survive in a less violent manner than now exists. Historically, we are just now learning how our behavior effects our children. We have identified basic physical and emotional needs which all human beings have at birth which must be met if they are to grow and develop into mature, responsible, caring adults. When many of the child's needs are not met over a period of time, he or she develops physical or behavioral symptoms which we now refer to as abuse or neglect. Parents Anonymous recognizes six forms: Physical abuse, physical neglect, emotional abuse, emotional neglect, verbal abuse, and sexual abuse.

Much of the acting out behavior children exhibit carries clear messages of unmet physical and/or emotional needs. Examples are: Truancy or underachievement in school, juvenile delinquency, emotional problems, such as depression or multiple personalities, running away. Suicide, psychological autopsies of suicide victims in California indicate emotional abuse or neglect prevalent in the families involved; drug and alcohol abuse; Parade magazine March 5, 1984, stated that strong supportive families help children overcome peer pressure to try drugs and alcohol and the example of the father was the strongest deterrent.

Teenage promiscuity and pregnancy—sexually promiscuous teenagers are often victims of sexual abuse. We often hear teenage girls say they become sexually active because they need to feel loved. Sometimes pregnancy occurs accidentally because of lack of information. Sometimes girls want a baby so they will have someone to love them. Crime—an LEA study in 1979 showed that 93 percent of the people serving time in the prisons they studied had been abused or neglected in some way as children. Virtually all the rapists they interviewed had been sexually abused.

Too often, adults react to the behavior, rather than the message it carries, which causes children to demonstrate louder messages through their behavior. If no one intervenes, or listens our children often grow up physically but not emotionally and find themselves still trying to get their own needs met and unable to meet their children's needs when they become parents.

Add to this the dissolution of the extended family as a support system and the added stress of the economy and societal pressures to be a perfect parent who should know all the answers about child rearing and we get several million families who are hurting. And so the cycle continues. The parents we shake our heads about and point our fingers at; the people who commit crimes and develop mental disorders; those who abuse their spouses; those who can't hold a steady job or get along with others, are very often grow up abused children. They can be found in all segments of our society. When they are young, we tend to feel sorry for them. When they grow up we ridicule and judge them or lock them up and put them down.

How can we respond to one another in a more supportive away and break the cycle of abuse?

As you have heard, Parents Anonymous is one organization whose philosophy is helping parents and children learn to help themselves. We believe in responding to parents who find themselves challenged and unable to parent the way they wish, in a nonjudgmental, supportive, caring manner. Remember, we are dealing with people who have low self-esteem, much guilt, no coping or parenting skills, little information about child development, and therefore, unrealistic expectations of their children, very low trust levels, many stresses in their lives, many unmet emotional needs, and are isolated both emotionally and physically from support systems.

Parents Anonymous has responded to these parents and children in a number of ways. The programs which have been developed and continue to be developed are based on what families say they need, not on what someone else thinks they need.

We try to reach parents before any serious problems occur, although many come to us as social service, private agency or court referrals. The chapter, which is a mutual support, guided self-help and parent education group is the traditional model we have used since the original concept was developed. Bringing together people who have common needs and concerns, helps break their isolation. They are unconditionally accepted and respected as people which helps them learn to like themselves and in turn, helps develop trust.

Parents develop a new sense of themselves; they learn skills to cope with stress; members and their sponsors establish a telephone support system which additionally aids in breaking their isolation; they learn how their children develop emotionally and ways to respond to their behavior that won't hurt anyone; they experience the feeling of being understood; parents experience a growth process which takes time, so they generally stay in a chapter for 1 to 3 years.

Volunteers are used as sponsors who guide the group's growth and development. They work closely with a parent leader called a chairperson. Parents are never charged a fee for joining a chapter. Empowering people to take responsibility for their own growth and change has proven to be a successful method of serving them.

We have long recognized the need to work with children in a structured way, while their parents are learning new skills. Early on, Parents Anonymous offered child care as a companion service but many chapters saw the potential of formalizing their child care. Our national organzation was also aware of the need to develop a national network of children's programs. Thirty sites were selected initially and given seed money to begin program development. Since then 15 additional sites have been funded. Richmond and Norfolk were selected in Virginia. Today, we have three successful programs in those areas, with three others in Charlottesville, Manassas, and the Eastern Shore. Two are therapeutic play programs for children under 12 whose parents are in chapters. The third is a teen support group for children 12 to 18. This group is open to children from the community, with parental permission, as well as those whose parents participate in Parents Anonymous.

Goals of these programs are to help children develop positive self-esteem; trust adult authority figures; learn to identify their feelings and express them in appropriate ways; learn to communicate with their peers, parents, and other adults; develop feelings of competency based on their age and developmental levels; learn to identify and use support systems which are available and develop social and coping skills.

We have tried a unique experiment for the last 1½ years with our Richmond play therapy program. We have a residential placement called the Methodist Children's Home, for children ages 7 to 18 who have been removed from their homes for reasons relating to child abuse and neglect. A cottage of eight boys 15 to 17 reached a personal growth level where they wanted to do some volunteer work in the community. When we became aware of their need we felt there was special potential for a mutually beneficial relationship between older abused children and younger ones.

We saw the older boys as having a unique sensitivity toward younger children who were having similar problems. We saw the chance to help the boys learn to nurture, to improve their self-esteem by being role models to younger children; and to demonstrate appropriate behavior control in this setting. We also felt the boys could help us learn more about the children we serve. Many of the children in this particular program come from single parent families and had no positive male role models in their lives. Many had difficulty trusting adults but might learn to trust a teenager.

The project has been a huge success. The feedback from counselors at the home has been overwhelmingly positive. Our program coordinator has been pleased as well. Two weeks ago, we began working with a second cottage of 11 boys. We have learned that everyone has something special to offer others if given the chance.

In May 1981, Parents Anonymous was made aware of the unique needs of the incarcerated mothers at the Virginia Correctional Center for Women in Goochland, VA. Inmates were concerned about the long separations from their children; they wanted to establish a support system within the institution to aid them in dealing with painful issues involving themselves and their families; and they wanted to learn parenting skills to assist them when they went home.

Parents Anonymous was contacted by the prison chaplain as an organization with national recognition, whose philosophy is supportive to parents and the self-help concept which might be interested in developing a program to meet their needs. Our awareness of the fact that most of them were abused or neglected in some way and probably had problems parenting before incarceration, regardless of their offense, prompted us to view this as a prevention experiment in a setting which may not be accepting of the self-help concept.

After many meetings with a core group of 12 inmates and after contacting every other female correctional institution in the country, we identified a team of professionals in various disciplines who agreed to volunteer their time to assist with the development of two of the seven program components now known as MILK [Mothers/Men Inside Loving Kids].

Other volunteers have been located to assist with the implementation of the other components. The MILK program consists of:

One, a series of child development classes.

Two, a series of parent education classes.

Three, ongoing support groups.

Four, extended visits with their children at the institution.

Five, a guardian support program.

Six, ways and means projects at the institution.

Seven, connection to Parents Anonymous chapters or other support systems when they return to their families.

We have an inmate board of directors which makes all policy decisions for the program. I, as the outside sponsor, and the chaplain, as the inside sponsor, guide the group and have equal votes as members of the board. Since 1981 when we started we have begun five MILK groups, serving a total of 132 women. Approximately 95 have returned to their families, 7 have dropped out of the program and 30 are currently members. Five have returned to the institution with other offenses. This recidivism rate is considerably lower than the 30 percent experienced by the general population at the institution.

We are currently helping Brunswick Correctional Center start the first Men Inside Loving Kids program in Lawrenceville, VA.

We have learned that the same self-help concepts used in the community can work within the correctional system and meet many of the emotional needs of incarcerated parents. In addition, we have allowed a few women who are not parents yet, to participate in the program to prepare them for the job before they have children.

We have identified additional program components which are needed to further meet the needs of our women. They are classes in self-esteem, assertiveness training, stress management and independent living skills. It costs approximately $5,000 per year to maintain the MILK program but to enlarge the scope of the program, and give technical assistance to other institutions requesting it, more funding is needed.

We base the success of the program on the unique relationship that exists among four groups of people: Parents Anonymous, the institutional administration, the inmates and the volunteers in the communities all over Virginia who support the program. Another program is offered women in the work release center in Richmond which consists of more intense parenting classes which are offered in the spring and fall.

Two men's institutions are interested in starting Parents Anonymous chapters for their inmates.

In Virginia, these services are coordinated by a State organization consisting of a board of directors, a part time executive director, a part time secretary and many dedicated volunteers. The organization exists on a very low budget, serving families for approximately $75 a year.

The most important lesson I have learned from working with families for 9½ years is this: if people are to become productive citizens and capable parents they must be able to do the following: Like themselves, have the ability to trust, feel secure, experience environmental stimulation by other people, and experience the freedom to be unique individuals, not extensions of someone else.

Prevention programs initially must be geared toward the individual and helping him/her meet the above stated emotions needs. All parenting classes in the world seem to fall on deaf ears if a person doesn't have a positive image of who he is, first. Once a person—the younger the better—feels OK about himself, then skills building to prepare for parenting is appropriate.

Many of us in different ways are trying to respond to the needs of families in various ways. Generally, we see a lack of coordination of services to families in many of our communities. Many times a family may be receiving services from several agencies, none of which are aware of what the other is doing. Each may be telling the family something different which, of course, is counterproductive.

In Virgina, 76 communities have established multidisciplinary teams for child abuse and neglect. These are made up of all the disciplines involved in the identification, treatment or prevention of child abuse. These teams try to assess community needs and respond to them as well as help social services staff cases and share information about what each agency is doing.

In addition, our Governor appointed an advisory committee on child abuse and neglect which suggests State policy and takes a part in appropriate statewide activities.

Since a National Child Abuse Prevention observance was proclaimed in 1982 we have formed the Virginia Coalition for Child Abuse Prevention which plans activities for the State and assists localities with technical assistance and materials. Nine organizations are now members with more wishing to join next year. Joe Theisman has agreed to be our honorary chairman this year.

Networking is the only way we will have a coordinated positive impact on hurting families. The National Committee for Prevention of Child Abuse and Parents United are two organizations with whom we work very closely in many areas.

In Virginia, Parents Anonymous and the Virginia chapter of NCPCA are preparing to share office space, a statewide hot line, materials and a secretary if we can find funding. We feel this effort will maximize our efforts and effectiveness and minimize our overlap.

We have made great strides in a relatively short period of time in Virginia, considering we were one of the last States to adopt any laws protecting children. However, gaps exist which must be discussed if we are to develop strategies to fill them.

When our most recent child abuse and neglect law was passed in 1975, the Department of Social Services was mandated to investigate reports of abuse and neglect. They were also mandated to set up a statewide hot line and central registry. All this had to be put in place in about 4 months time. Social workers had no formal training in child protective services in college or on the job prior to the law. Before 1975, less than 400 cases per year were reported statewide. During the first year after the law was passed, 10,000 reports were received. Workers were totally overwhelmed and had few services to offer families.

Needless to say many families have been underserved and mishandled due to the lack of training and resources. The Virginia Department of Social Services was aware of the problem early on. After a 3 year search for funding an experimental training program was created which is superior. Training has begun for the 600 workers statewide who need it. Another major concern for qualified workers is the elimination of a social work degree as a criterion for employment in a social service agency. We have history majors investigating child abuse and neglect cases in some areas while MSWs are unemployed.

This may differ from college to college, but many schools of social work do not have undergraduate or gradaute classes in child abuse investigation, treatment or prevention. Agencies should be able to share information regarding training needs with local universities which should then develop classroom training which is relevant.

Another major concern is the placement of abused and neglected children in foster care and adoptive homes. They are formally classified as special needs children but the families in whose care they are committed receive no special training to help them deal with many problems brought with them. Families are at a loss when trying to deal with some of the behavior problems which exist. The children get no special counseling and there is no after care for anyone, once a child is adopted.

We have treated many parents in Parents Anonymous who, as children, were abused or neglected in foster homes or moved each time they acted up. They have grown up to find themselves hardly able to parent their own children. Parents Anonymous of Virginia was asked to develop and present a workshop for foster and adoptive families at their national conference on this topic. I was amazed to find many parents who desperately wanted training to help them deal with their special needs children. Some local foster parent associations are just now starting support groups, training sessions and counseling groups for their children. Small amounts of funding are needed to help this effort. I see Parents Anonymous as being capable of lending assistance.

With all the cutbacks in agency funding we have seen caseloads go as high as 80 per worker because of staff cutbacks. If prevention programs were available, they were the first to go. Federal funding streams tend to be categorical in nature. Services such as Aid to Dependent Children, foster care and adult services end up receiving the largest allocations. Prevention programs are at the bottom of the priority list. Could the Government not develop guidelines which encourage States to prioritize prevention programs differently?

In view of staff and service cutbacks, I see community resources such as Parents Anonymous being underused by local agencies. In some cases professionals seem threatened by the idea of self-help. In others, turfism exists; in still others workers simply don't think to use Parents Anonymous as part of their initial treatment plan; only as a last resort. A staff person from the State Department of Social Services and I have developed a half day workshop for local agencies to help deal with various barriers which may exist toward using Parents Anonymous for a client. We also offer training on how to effectively refer a parent by developing liaisons with their local Parents Anonymous chapters and using them in the referral process.

We see several cultural barriers for parents who need help. Many minority groups feel their destructive behavior toward their children is justified and acceptable. We need to educate parents more about appropriate parenting techniques and the effects of severe discipline, et cetera. We have noticed that social workers don't receive adequate training for serving minority families. We need to make stronger efforts to reach and understand our minority populations.

We are also not reaching middle class parents who are hurting. Our society expects us to somehow know all the answers to parenting our children when we physically have them and tends to look down on those who have difficulty. Therefore, families go to great lengths to cover up their problems for fear of losing their children, social position or respect in their communities. The higher the socio-economic level of a family, the more means they have of covering up the problem.

We need to help people feel more comfortable about accepting the fact that they don't have all the answers and that it is acceptable and even responsible to ask for help with this every challenging job. All of us must gear some of our literature and public awareness information to this fact. One of the best pieces of literature produced by Health and Human Services was a comic book for parents featuring Dennis the Menace. It dealt with this issue beautifully. They printed a million copies which were gone within a few months. They need money to print more. We miss having them to give to parents.

We see a gap in services available for sexually abusive families. We are just experiencing an awakening to this form of abuse as a widespread problem. One in four women in the United States by the age 18 has been sexually abused in some way. As a result of television programs and magazine articles recently, victims are coming foward for help and many of our communities simply haven't any available. We are developing sexual abuse trauma teams to investigate cases and begin working with families immediately. We have structured family therapy, individual therapy, and Parents United. All are part of a total support system for parents. However, the tidewater area of our State and Roanoke are the only ones in which all the above types of service exist. Parents Anonymous serves sexually abusive families where no other resources exist. In fact, the spouses of perpetrators do very well in Parents Anonymous chapters and their children are being served through our kids programs. However, support groups for young adult victims of sexual, as well as other forms of abuse, are still needed. Community professionals need educating about the effectiveness of these resources and encouragement to support their development.

We see little coordination of service development for families among the major agencies such as social services, mental health and corrections. All receive State and Federal funding to operate but all seem to have different priorities even though they all may be serving the same families. The boards of these agencies might try some coordination of priorities, goals and program strategies, in the form of prescription teams.

Corrections in Virginia are experiencing major budget cutbacks. Prevention and treatment programs were the first to go. There are staff cutbacks taking place which are putting enormous pressure on remaining staff and inmates. The State penitentiary in Richmond, for example, has just lost four counselors, leaving six to handle 900 prisoners. I see the potential of many community agencies offering volunteer services to restore some of what has been lost, but the prisons don't have volunteer coordinators. Therefore, no mechanism exists to utilize what I suspect to be a variety of services to prisoners.

We see few services in our communities for the families of prisoners. The children of prisoners are often ostracized, lonely, and isolated. We see them continue the cycle of crime in part because we are not responding to their needs for acceptance and emotional support. I see schools as being an integral part of the support system here as well as the juvenile-justice system if they (children) are in trouble. Parents Anonymous is looking at the possibility of setting up community peer-support groups for adolescents whose parents are incarcerated.

Schools could be playing a much larger part in child-abuse prevention by offering family-life education and child-development classes to high school students. In Virginia, our Department of Education feels very uncomfortable with this role, confusing it with sex education and teaching morals. Many of us involved in this field supported the bill in our general assembly this year asking that family-life education be mandated in high schools. It was continued until next year.

We also see teachers who have not been trained to work with abused and neglected children in the classroom. Many of them act out frequently. Instead, teachers often overrespond to the negative behavior, adding to the child's pain. Some schools do have inservice training in this area but more needs to be done on the college level in preparing teachers to deal effectively with special-needs children. Parents Anonymous has found that staffings with school personnel regarding children whose parents are in Parents Anonymous have been helpful. With the parents permission we are able to suggest ways of dealing with a particular child in the classroom that we have found successful in our kids program. We can also act as parent advocates and interpreters if parents and teachers have difficulty communicating without feeling angry or threatened.

Last, we see a lack of funding on the State and national levels for programs which are proven effective. We find ourselves constantly writing grant proposals with a new twist to catch someone's eye when we could be developing and coordinating our programs which serve families. I believe moneys should be set aside for credible, effective programs as well as funding for new ideas. Programs like Parents Anonymous are so cost effective we don't need large amounts of money, but we do need a more solid funding base both on our State and national levels.

Networking, cooperating, and sharing are the keys to our success. The collection and dissemination of information about organizations, agencies, and program help us assess family, and community needs, and keeps us informed about what is being done to address them. It is my hope that the Government can take an active role in filling a gap being created by the dismantling of our Regional Resource Centers for Children, Youth, and Families. They have been major conduits for the flow of information and have brought many of us together who have common goals.

Our center helped us develop a regional Parents Anonymous consortium which has greatly enhanced our networking ability. The center also created a consortium for all the Social Service Commissioners. The two groups are planning a joint conference at the end of May which will deal with compliance to Public Law 96-272. When the centers close, all the resources materials which we now borrow will be absorbed by the universities where the centers are located. Please be aware of the effect of your decision regarding the centers and look at the possibilities of maintaining and sharing information and resources through the National Center for Child Abuse and Neglect.

In closing, I believe we have learned and continue to learn much about how to prevent child abuse and neglect. Our challenge is to learn how to use the resources we have and creatively, collectively mobilize additional ones to more successfully meet family needs.

[Prepared statement of Johanna Schuchert follows:]

PREPARED STATEMENT OF JOHANNA SCHUCHERT, EXECUTIVE DIRECTOR, PARENTS ANONYMOUS OF VIRGINIA

Mr. Chairman, members of the committee, as you have heard from other members of this panel child abuse and neglect is a major national concern which we must come to terms with if our society is to survive in a less violent manner than now exists. Historically, we are just now learning how our behavior effects our children. We have identified basic physical and emotional needs which all human beings have at birth which must be met if they are to grow and develop into mature, responsible, caring adults. When many of a child's needs are not met over a period of time he/she develops physical and or behavioral symptoms which we now refer to as abuse or neglect. Parents Anonymous recognizes 6 forms. Physical abuse, physical neglect, emotional abuse, emotional neglect, verbal abuse, and sexual abuse.

Much of the acting out behavior children exhibit carries clear messages of unmet physical and/or emotional needs. Examples are: truancy or underachievement in school, juvenile delinquency, emotional problems, such as depression or multiple personalities, (9 out of 10 adults suffer from multiple personalities were sexually abused); running away (70% of the runaways in this country are running from some form of abuse; over half are running from sexual abuse.); Suicide (psychological autopsies of suicide victims in California indicate emotional abuse or neglect prevalent in the families involved); drug and alcohol abuse (Parade magazine March 5, 1984, stated that strong supportive families help children overcome peer pressure to try drugs and alcohol and the example of the father was the strongest deterrent.); Teenage promiscuity and pregnancy (sexually promiscuous teenagers are often victims of sexual abuse. We often hear teenage girls say they become sexually active because they need to feel loved. Sometimes pregnancy occurs accidentally because of lack of information. Sometimes girls want a baby so they will have someone to love *them.*); crime—(An LEAA study in 1979 showed that 93% of the people serving time in the prisons they studied had been abused or neglected in some way as children. Virtually all the rapists they interviewed had been sexually abused).

Too often, adults react to the behavior, rather than the message it carries, which causes children to demonstrate louder messages through their behavior. If no one intervenes, or listens our children often grow up physically but not emotionally and find themselves still trying to get their own needs met and unable to meet their children's needs when they become parents. Add to this the dissolution of the extended family as a support system and the added stress of the economy and societal pressures to be a "perfect" parent who should know all the answers about child rearing and we get several million families who are hurting. And so the cycle continues. The parents we shake our heads about and point our fingers at; the people who commit crimes and develop mental disorders; those who abuse their spouses; those who can't hold a steady job or get along with others, are very often grown up abused children. They can be found in segments of our society. When they are young, we tend to feel sorry for them. Whey they grow up we ridicule and judge them or lock them up and "put them down".

How can we respond to one another in a more supportive way and break the cycle of abuse?

As you have heard, Parents Anonymous is one organization whose philosophy is helping parents and children learn to help themselves. We believe in responding to parents who find themselves challenged an unable to parent the way they wish, in a non-judgmental, supportive, caring manner. Remember, we are dealing with people who have low self-esteem, much guilt, no coping or parenting skills, little information about child development, and therefore, unrealistic expectations of their children, very low trust levels, many stresses in their lives, many unmet emotional needs, who are isolated both emotionally and physically from supportive systems.

Parents Anonymous has responded to these parents and children in a number of ways. The programs which have been developed and continue to be developed are based on what families say they need, not on what someone else thinks they need.

We try to reach parents before any serious problems occur, although many come to us as social service, private agency or court referred. The Chapter, which is a mutal support, guided self-help and parent education group is the traditional model we have used since the original concept was developed. Bringing together people who have common needs and concerns, helps break their isolation. They are unconditionally accepted and respected as people which helps them learn to like themselves and in turn helps develop trust. Parents develop a new sense of themselves; they learn skills to cope with stress; members and their sponsor establish a telephone support system which additionally aids in breaking their isolation; they learn how their children develop emotionally and ways to respond to their behavior that won't hurt anyone; they experience the feeling of being understood; parents experience a growth process which takes time, so they generally stay in a Chapter from one to three years.

Volunteers are used as sponsors who guide the group's growth and development. They work closely with a parent leader called a Chairperson. Parents are never charged a fee for joining a Chapter. Empowering people to take responsibility for their own growth and change has proven to be a successful method of serving them.

We have long recognized the need to work with children in a structured way, while their parents are learning new skills. Early on, Parents Anonymous offered child care as a companion service but many Chapters saw the potential of formalizing their child care. Our national organization was also aware of the need to better serve children and, therefore initiated a 2-year project aimed at developing a national network of children's programs. 30 sites were selected initially and given seed monies to begin program development. Since then 15 additional sites have been funded. Richmond and Norfolk were selected in Virginia. Today, we have 3 successful programs in those areas, with three others in Charlottesville, Manassas, and the Eastern Shore. Two are therapeutic play programs for children under 12 whose parents are in Chapters. The third is a teen support group for children 12–18. This group is open to children from the community, with parental permission, as well as those whose parents participate in P.A. Goals of these programs are to help children develop positive self-esteem; trust adult authority figures; learn to identify their feelings and express them in appropriate ways; learn to communicate with their peers, parents and other adults; develop feelings of competency based on their age and developmental levels; learn to identify and use support systems which are available; and develop social and coping skills.

We have tried a unique experiment for the last 1½ years with our Richmond play therapy program. We have a residential placement called the Methodist Children's Home, for children ages 7–18 who have been removed from their homes for reasons relating to child abuse and neglect. A cottage of eight boys ages 15–17 reached a personal growth level where they wanted to do some volunteer work in the community. When we became aware of their need we felt there was special potential for a mutually beneficial relationship between older abused children and younger ones. We saw the older boys as having a unique sensitivity toward younger children who were having similar problems. We saw the chance to help the boys learn to nurture; to improve their self-esteem by being role models to younger children; and to demonstrate appropriate behavior control in this setting. We also felt the boys could help us learn more about the children we serve. Many of the children in this particular program come from single parent families and had no positive male role models in their lives. Many had difficulty trusting adults but might learn to trust a teenager.

The project has been a huge success. The feedback from counselors at the home has been overwhelmingly positive. Our program coordinator has been pleased as well. Two weeks ago, we began working with a second cottage of 11 boys. We have learned that everyone has something special to offer others if given the chance.

In May, 1981, Parents Anonymous was made aware of the unique needs of the incarcerated mothers at the Virginia Correctional Center for Women in Goochland, Virginia.

Inmates were concerned about the long separations from their children; they wanted to establish a support system within the institution to aid them in dealing with painful issues involving themselves and their families; and they wanted to learn parenting skills to assist them when they went home.

Parents Anonymous was contacted by the prison Chaplain as an organization with national recognition, whose philosophy is supportive to parents and the self-help concept which might be interested in developing a program to meet their needs. Our awareness of the fact that most of them were abused or neglected in some way and probably had problems parenting before incarceration, regardless of their offense, prompted us to view this as a prevention experiment in a setting which may not be accepting of the self-help concept. After many meetings with a core group of 12 inmates and after contacting every other female correctional institution in the country, we identified a team of professionals in various disciplines who agreed to volunteer their time to assist with the development of two of the seven program components now known as M.I.L.K. (Mother/Men Inside Loving Kids). Other volunteers have been located to assist with the implementation of the other components. The M.I.L.K. program consists of 1. a series of child development classes, 2. a series of parent education classes, 3. on-going support groups, 4. extended visits with their children at the institution, 5. a guardian support program, 6. ways and means projects at the institution and 7. connection to Parents Anonymous Chapters or other support systems when they return to their families. We have an inmate board of directors which makes all policy decisions for the program. I, as the outside sponsor and the chaplain, as the inside sponsor, guide the group and have equal votes as members of the board. Since 1981, when we started (13 of whom joined the original 12) we have begun 5 M.I.L.K. groups, serving a total of 132 women. Approximately 95 have returned to their families. 7 have dropped out of the program and 30 are currently members. 5 have returned to the institution with other offenses. This recidivism rate is considerably lower than the 30% experienced by the general population at the institution.

We are currently helping Brunswick Correctional Center start the first Men Inside Loving Kids program in Lawrenceville, Viriginia.

We have learned that the same self-help concepts used in the community can work within the correctional system and meet many of the emotional needs of incarcerated parents. In addition we have allowed a few women who are not parents yet, to participate in the program to prepare them for the job before they have children.

We have identified additional program components which are needed to further meet the needs of our women. They are classes in: self-esteem, assertiveness training, stress management and independent living skills. It costs approximately $5,000 per year to maintain the MILK program but to enlarge the scope of the program and give technical assistance to other institutions requesting it more funding is needed.

We base the success of the program on the unique relationship that exists among four groups of people: Parents Anonymous, the institutional administration, the inmates and the volunteers in the communities all over Virginia who support the program. Another program is offered women in the work release center in Richmond which consists of more intense parenting classes which are offered in the spring and fall.

Two men's institutions are interested in starting P.A. Chapters for their inmates.

In Virginia, these services are coordinated by a state organization consisting of a Board of directors, a part-time executive director, a part-time secretary and many dedicated volunteers. The organization exists on a very low budget, serving families for approximately $75 per year.

Our national office in California provides many support services to our state and local organizations and is the glue which keeps us connected nationwide. We have deep concerns about the possibility of our national office not remaining open due to funding cuts. The credibility of being part of a national organization is real. The services and products they offer us enhance what we offer families and the leadership of national staff guides us in providing the services just described.

The most important lesson I have learned from working with families for 9½ years is this: if people are to become productive citizens and capable parents they must be able to do the following: like themselves, have the ability to trust, feel secure, experience environmental stimulation (by other people) and experience the freedom to be unique idividuals not extensions of someone else.

Prevention programs initially must be geared toward the individual and helping him/her meet the above stated emotional needs. All the parenting classes in the world seem to fall on deaf ears if a person doesn't have a positive image of who he is, first. Once a person (the younger, the better) feels okay about himself, then skills building to prepare for parenting are appropriate.

Many of us in different ways are trying to respond to the needs of families in various ways. Generally, we see a lack of coordination of services to families in many of our communities. Many times a family may be receiving services from several agencies, none of which are aware of what the other is doing. Each may be telling the family something different which, of course is counterproductive.

In Virginia, 76 communities have established Multidisciplinary Teams for Child Abuse and Neglect. These are made up of all the disciplines involved in the identification, treatment or prevention of child abuse. These teams try to assess community needs and respond to them as well as helping social services staff cases and sharing information about what each agency is doing.

In addition our governor appointed an advisory committee on child abuse and neglect which suggests state policy and takes a part in appropriate statewide activities.

Since a National Child Abuse Prevention observance was proclaimed in 1982 we have formed the Virginia Coalition for Child Abuse Prevention which plans activities for the state and assists localities with technical assistance and materials. Nine organizations now are members with more wishing to join next year. Joe Theisman has agreed to be our honorary chairman this year.

Networking is the only way we will have a coordinated positive impact on hurting families. The National Committee for the Prevention of Child Abuse and Parents United are two organizations with whom we work very closely in many areas.

In Virginia, Parents Anonymous and the Virginia Chapter of NCPCA are preparing to share office space, a statewide hot line, materials and a secretary if we can find funding. We feel this effort will maximize our efforts and effectiveness and minimize our overlap.

We have made great strides in a relatively short period of time in Virginia, considering we were one of the last states to adopt any laws protecting children. However, gaps exist which must be discussed if we are to develop strategies to fill them.

When our most recent child abuse and neglect law was passed in 1975, the Department of Social Services was mandated to investigate reports of abuse and neglect. They were also mandated to set up a statewide hotline and central registry. All this had to be put in place in about four months time. Social workers had no formal training in child protective services in college or on the job prior to the law. Before 1975, less than 400 cases per year were reported statewide. During the first year after the law was passed, 10,000 reports were received. Workers were totally overwhelmed and had few services to offer families. Needless to say many families have been underserved and mishandled due to lack of training and resources. The Virginia Department of Social Services was aware of the problem early on. After a 3-year search for funding an experimental training program was created which is superior. Training has begun for the 600 workers statewide who need it. Another major concern for qualified workers is the elimination of a social work degree as a criterion for employent in a social service agency. We have history majors investigating child abuse and neglect cases in some areas while MSW's are unemployed.

This may differ from college to college but many schools of social work do not have undergraduate or graduate classes in child abuse investigation, treatment or prevention. Agencies should be able to share information regarding training needs with local universities which should then develop classroom training which is relevant.

Another major concern is the placement of abused and neglected children in foster care and adoptive homes. They are formally classified as "special needs" children but the families in whose care they are committed receive no special training to help them deal with the many problems brought with them. Families are at a loss when trying to deal with some of the behavior problems which exist. The children get no special counseling and there is no after care for anyone, once a child is adopted. We have treated many parents in P.A. who, as children, were abused or neglected in foster homes or moved each time they acted out. They have grown up to find themselves hardly able to parent their own children. Parents Anonymous of Virginia was asked to develop and present a workshop for foster and adoptive families at their national conference on this topic. I was amazed to find many parents who desperately wanted training to help them deal with their "special needs" children. Some local Foster Parent Associations are just now starting support groups, training sessions and couseling groups for their children. Small amounts of funding are needed to help this effort. I see Parents Anonymous as being capable of lending assistance.

With all the cutbacks in agency funding we have seen case loads go as high as 80 per worker because of staff cutbacks. If prevention programs were available, they were the first to go. Federal funding streams tend to be catagorical in nature. Services such as Aid to Dependent Children, foster care and adult services end up receiving the largest allocations. Prevention programs are at the bottom of the priority list. Could the government not develop guidelines which encourage states to prioritise prevention programs differently.

In view of staff and service cutbacks, I see community resources such as Parents Anonymous being underused by local agencies. In some cases professionals seem threatened by the idea of self-help. In others, turfism exists; in still others workers simply don't think to use P.A. as part of their initial treatment plan; only as a last resort. A staff person from the State Department of Social Services and I have developed a ½ day workshop for local agencies to help deal with various barriers which may exist toward using P.A. for a client. We also offer training on how to effectively refer a parent by developling liasons with their local P.A. Chapters and using them in the referral process.

We see several cultural barriers for parents who need help. Many minority groups feel their destructive behavior toward their children is justified and acceptable. We need to educate parents more about appropriate parenting techniques and the effects of severe discipline, etc. We have noticed that social workers don't receive adequate training for serving minority families. We need to make stronger efforts to reach and understand our minority populations.

Many cities in our state have become the new homes for Asian refugees. Some of their child rearing practices, according to our laws, are inappropriate. They also find themselves under enormous stress, related to language barriers, financial and job related concerns and isolation. Support systems are being formed, but our service agencies who become involved with these families, often find themselves forcing our cultural values on people who have no frame of reference to understand.

We have the mountain people in Southwest Virginia who still feel that severe physical punishment is appropriate discipline and become very angry and defensive when the community tries to intervene. Social workers are sometimes met by dad holding a shotgun.

Our migrants and fishermen on the Eastern Shore are two other groups who have unique life styles. Legally, some of their parenting practices are regarded as neglect.

We have also had to deal with the parenting practices of religious cults which are sometimes seen as abusive or neglectful.

Our black populations, both inner city and rural, sometimes have values which contradict the law and/or community values. An example involves a black male inmate who I worked with in a group last year, who is from one of our cities. We were talking about appropriate discipline. He believed that a responsible way to teach his son to be more respectful to his mother, was to point a gun at him and threaten "to blow his head off", if he didn't straighten up. The father had used this method many times.

According to statistics, 22 percent of our population are black, 86 percent are white and 2 percent are other. Last year, 33 percent of the reported cases of abuse and neglect in Virginia were black; 65 percent were white, and 2 percent were other.

These figures indicate that we must try to better understand our minority populations and find ways of protecting their children without threatening their cultural values.

We can, in fact, learn much from them. Many of our minority groups for example, still have the extended family as a support system.

It is my belief that white families are not reported as often as minority families, for abuse and neglect, so the above statistics may not be a valid indicator of proportionate child maltreatment.

I feel that more interaction on social, education and service levels among all our populations may serve to bridge the gap. Training of service providers for minority groups may also assist the process of learning to respect and protect all cultures represented in our communities.

We are also not reaching middle class parents who are hurting. Our society expects us to somehow know all the answers to parenting our children when we physically have them and tends to look down on those who have difficulty. Therefore, families go to great lengths to cover up their problems for fear of losing their children, social position or respect in their communities. The higher the socio-economic level of a family the more means they have of covering up the problem. We need to help people feel more comfortable about accepting the fact that they don't have all the answers and that it is acceptable and even responsible to ask for help with this very challenging job. All of us must gear some of our literature and public awareness information to this fact. One of the best pieces of literature produced by Health and Human Services was a comic book for parents featuring Dennis the Menace. It dealt with this issue beautifully. They printed a million copies which were gone within a few months. They need money to print more. We miss having them to give to parents.

We see a gap in services available for sexually abusive families. We are just experiencing an awakening to this form of abuse as a wide-spread problem. One in four women in the U.S. by the age of 18 has been sexually abused in some way. As a result of television programs and magazine articles recently, victims are coming forward for help and many of our communities simply haven't any available. We are developing sexual abuse trauma teams to investigate cases and begin working with families immediately. We have structured family therapy, individual therapy, and Parents United. All are part of a total support system for parents. However, the Tidewater area of our state and Roanoke are the only ones in which all the above types of service exist. Parents Anonymous serves sexually abusive families where no other resources exist. In fact, the spouses of perpetrators do very well in P.A. Chapters and their children are being served through our kids programs. However, support groups for young adult victims of sexual, as well as other forms of abuse are still needed. Community professionals need educating about the effectiveness of these resources and encouraged to support their development.

We see little coordination of service development for families among the major agencies such as social services, mental health and corrections. All receive state and federal funding to operate but all seem to have different priorities even though they all may be serving the same families. The boards of these agencies might try some coordination of priorities, goals and program strategies, in the form of prescription teams.

Corrections in Virginia are experiencing major budget cutbacks. Prevention and treatment programs were the first to go. There are staff cutbacks taking place which are putting enormous pressure on remaining staff and inmates. The state penitentiary in Richmond, for example, has just lost 4 counselors, leaving 6 to handle 900 prisoners. I see the potential of many community agencies offering volunteer services to restore some of what has been lost, but the prisons don't have volunteer coordinators. Therefore, no mechanism exists to utilize, what I suspect to be, a variety of services to prisoners.

We see few services in our communities for the families of prisoners. The children of prisoners are often ostracized, lonely, and isolated. We see them continue the cycle of crime inpart because we are not responding to their needs for acceptance and emotional support. I see schools as being an integral part of the support system here as well as the juvenile justice system if they are in trouble. Parents Anonymous is looking at the possibility of setting up community peer support groups for adolescents whose parents are incarcerated.

Schools could be playing a much larger part in child abuse prevention by offering family life education and child development classes, to high school students. In Virginia, our Department of Education feels very uncomfortable with this role, confusing it with sex education, and teaching morals. Many of us involved in this field supported a bill in our general assembly this year asking that family life education be mandated in high schools. It was continued until next year.

We also see teachers who have not been trained to work with abused and neglected children in the classroom, many of whom act out frequently. Instead, they often over-respond to the negative behavior, adding to the child's pain. Some schools do have inservice training in this area but more needs to be done on the college level in preparing teachers to deal effectively with special needs children. Parents Anonymous has found that staffings with school personnel regarding problem children whose parents are in P.A., have been helpful. With the parents permission we are able to suggest ways of dealing with a particular child in the classroom that we have found successful in our kid's program. We can also act as parent advocates and interpreters if parents and teachers have difficulty communicating without feeling angry or threatened.

Lastly, we see a lack of funding on the state and national levels for programs which are proven effective. We find ourselves constantly writing grant proposals with a new twist to catch someone's eye when we could be developing and coordinating our programs which serve families. I believe monies should be set aside for credible, effective programs as well as funding for new ideas. Programs like Parents Anonymous are so cost-effective we don't need large amounts of money, but we do need a more solid funding base both on our state and national levels.

Networking, cooperating and sharing are the keys to our success. The collection and dissemination of information about organizations, agencies and programs help us assess family and community needs and keeps us up with what is being done to address them. It is my hope that the government can take an active role in filling a gap being created by the dismantling of our Regional Resource Centers for Children, Youth, and Families. They have been major conduits for the flow of information and have brought many of us together who have common goals. Our center helped us developed a regional Parents Anonymous consortium which has greatly enhanced our networking ability. The center also created a consortium for all the Social Service Commissioners. The two groups are planning a joint conference at the end of May, which will deal with compliance to PL 96-272. When the centers close, all the resource materials which we now borrow will be absorbed by the universities where the centers are located. Please be aware of the effect of your decision regarding the centers and look at the possibilities of maintaining and sharing information and resources through the National Center for Child Abuse and Neglect.

In closing, I believe we have learned and continue to learn much about how to prevent child abuse and neglect. Our challenge is to learn how to use the resources we have and creatively, collectively mobilize additional ones to more successfully meet family needs.

Mr. ANTHONY. Mr. Green.

STATEMENT OF FREDERICK C. GREEN, M.D., ASSOCIATE DIRECTOR, CHILDREN'S HOSPITAL, NATIONAL MEDICAL CENTER, WASHINGTON, DC

Dr. **Green**. I will take the time alloted to me to highlight the salient points of my testimony. My testimony will focus primarily on hospital-based child abuse programs and look specifically at three such programs at the Children's Hospital National Medical Center [CHNMC] here in Washington, DC.

I am Dr. Frederick Green. I am a pediatrician and associate director of CHNMC. I am also the director of the hospital's Office of Child Health Advocacy, a professor of child health and development at George Washington University, and vice president of the National Committee To Prevent Child Abuse and Neglect.

Hospitals have been called gatekeepers for the identification of child abuse and neglect. That is, sooner or later, child victims usually are brought to a hospital—to an emergency room if their condition is acute, or to some department if their problem is less immediately threatening to life or limb. When this happens, specially trained and highly skilled health professionals will be able to diagnose the clinical symptoms and initiate appropriate interventions. This is a vital aspect of hospital services, but it is by no means the only service hospitals can provide for children at risk of maltreatment. Hospitals can also be gatekeepers for the prevention of child abuse and neglect.

At CHNMC, preventive efforts are focused in the Office of Child Health Advocacy. This office was established in 1973 as a concrete expression of the hospital's commitment to meeting the needs of the whole child by going beyond the walls of the institution, to join forces with the community we serve. As further reflection of this commitment, OCHA has been placed sufficiently high in the hospital's administrative and management structure to ensure that it has adequate purview to accomplish its mission.

Primary prevention is the principal mission of OCHA's largest outreach arm, the Comprehensive Health Care Program. Through this program's two neighborhood clinics, we have been able to offer thousands of the District of Columbia's neediest children the primary, preventive health care that is their due and their entitlement. This care is essential in ensuring the early identification of children and families at-risk for abuse or neglect. It also provides us with continuing opportunities for educational interactions with parents, helping them understand normal child development and develop realistic expectations for their children's capabilities and behavior.

OCHA also has carried its prevention efforts into the District of Columbia public schools. The school health project, established in 1981, involves medical students from George Washington University in educational outreach with District junior and senior high school students. Over 100 medical students and 500 schoolchildren have now participated in the program, which has the goals of providing young people with the information they need to make informed decisions about their own health and well-being and that of their children or future children, and providing physicians-in-training with community health knowledge, skills, and experience.

The common denominator of all these programs, as well as others under the OCHA umbrella, is prevention tailored to community needs.

Our efforts specifically on behalf of abused and neglected children provide a classic illustration of advocacy in action to protect child health. These efforts began in the late sixties, and, by 1975, we were successful in obtaining funds from the National Center on Child Abuse and Neglect to establish a national demonstration project which we called the Child Protection Center. This effort was expanded in 1978 when the Law Enforcement Assistance Administration granted us funds for a special unit to care for child victims of sexual abuse.

A reorganization of these programs in 1982 brought both staffs together into a single administrative unit called the Division of Child Protection. The original grant funds have long since expired, and the division is currently struggling to maintain its fiscal balance with a precarious combination of medicaid and other third party reimbursements, hospital support, and a patchwork of relatively small public and private grants and contracts.

In 1983, the Division's clinical teams managed over 1,000 cases of child maltreatment. Over 90 percent of the caseload is black, most reside in the city, and at least 60 percent are low-income. The average age of child victims of physical abuse or neglect is 3 to 5 years, while the average age of sexually victimized children is 8 to 9 years. There is a span from 3 months through 18 years.

The fundamental mission of the Division is to protect individual child victims from reabuse—secondary prevention—and to protect potential victims from harm—primary prevention. The critical pathway to secondary prevention is—of course—the treatment provided to the abused child and his or her family.

In cases of battering or neglect, treatment goals may include helping the parent to gain a cognitive understanding of what happened in relation to the abusive incident and what the potenital or actual consequences may be; reinforcing the parents' positive or adaptive parenting skills; enhancing the parents' ability to recognize and confront stress constructively, et cetera.

The central concern is to maintain the family unit if at all possible and to strengthen it so as to assure the future health and well-being of the child.

The success of the Division's treatment approach in halting the abusive cycle has been amply demonstrated. Recidivism; this is, repeated incidents of abuse of a child, occurs in less than 8 percent of validated cases.

This is a striking finding when one considers recidivism is about 50 percent in cases of child abuse in which no intervention is made.

In addition to its extensive case management responsibilities, the division also carries out research, organizes and implements a wide variety of professional and community education programs, and provides legal support services, such as court accompaniment. With specific reference to prevention programs, three division initiatives stand out, and I would like to describe each briefly.

The Division's Parenting Skills Education Program provides the District with a valuable resource that meets the needs both of parents and of other providers of child abuse and neglect services. The purpose of the program is to offer specific instructions to modify abusive parenting behavior. The objectives of the program are: (1) to acquaint parents with the normal growth and development patterns of children, (2) to identify alternative disciplinary approaches and techniques necessary for healthy childrearing, and (3) to facilitate management of specific common childrearing issues.

The program is entirely voluntary. Any parent is eligible to participate. Referrals are accepted from court social services, protective services, foster care, legal aid, and a number of other agencies. In addition to knowledge gained, the classes also have therapeutic value. Parents receive group support when they engage in class activities, an especially important benefit for abusive parents who tend to be isolated and to lack informal support networks.

Another of our programs I would like to share with you is the school-based sexual abuse prevention program. In spite of the prevalence and seriousness of child sexual abuse, most children receive little or no information about this hazard and are not taught effective techniques for protecting themselves. A child may receive vague warnings about not talking to strangers, but the reason for this prohibition is usually left clouded. Moreover, most children who are sexually victimized are abused by someone they know. Often, the offender is a member of the child's family or a close associate of a family member. There is perhaps no other actual or potential danger faced by children that is so completely obscured by parents, educators, health professionals, and our society as a whole.

The Division's school-based sexual abuse prevention program is designed to address this issue. Its purpose is to help children understand what is meant by sexual abuse, teach them ways to protect themselves from being abused, and acquaint them with sources of help if they are being abused, have been abused, or are abused in the future.

It is also intended to educate parents about the nature and extent of sexual abuse, ways in which they can protect their children, and where they can get help if abuse occurs. Finally, the program is designed to train school personnel in the identification and reporting of abuse, as well as in getting assistance for abused children who come to their attention. The program is now in its 3d year, working with third and fourth grade students, parents, and educators in four District elementary schools.

Our Juvenile Abuser Treatment Program is the final program I would like to discuss today. I have been a serious student of child maltreatment over the years. At the present time, I know of no evidence to suggest a genetic basis for child maltreatment. While the two program components discussed above are directed toward primary prevention, the division also stresses secondary prevention as is exemplified in the Juvenile Abuser Treatment Program. This program, initiated in 1981 with grant funds from the National Center on Child Abuse and Neglect, provides both short- and long-term outpatient treatment for adolescents who sexually molest younger children. The program functions as both a pre- and post-adjudication diversionary placement for the juvenile justice systems in the District of Columbia and surrounding jurisdictions.

The JATP was established as a result of the growing awareness on the part of division staff about the magnitude of the problem of sexual abuse by adolescents. Of the 1,600 cases of sexual abuse known to the division, 47 percent involved juvenile offenders, with over 32 percent of these involving family members.

Regardless of the offender's familial relationship to the victim, these abusive incidents usually have negative psychological and social consequences for the victimized child, the adolescent abuser, and the family members of both the victim and offender. Moreover, current research findings indicate that most adult sexual offenders begin their sexually assaultive behavior during adolescence, usually victimizing younger children. Quite simply, current research and treatment findings suggest that the adolescent sexual abuser of today, if untreated, is likely to be the adult sexual offender of tomorrow. Yet, despite the prevalence and seriousness of this problem, little is known about its etiology or the most efficacious treatment of juvenile sexual abusers and their families.

JATP seeks to develop, evaluate, and ultimately disseminate a specialized model for effective intervention and treatment of the juvenile sexual abuser. This treatment model is designed to: (1) enhance family stability by reducing the frequency with which either juvenile abusers or their victims are removed or expelled from the home; (2) demonstrate success in cognitive restructuring and behavioral modification of juvenile abusers in areas related to their abusive behavior; (3) provide sufficient flexibility and comprehensiveness to be accessible to the majority of juvenile offenders; and (4) be cost-effective when compared to alternative approaches.

Although it is too early to speak of conclusive findings, preliminary program data and clinical observations are encouraging. To date, there has been no identified recidivism by the adolescents who have entered treatment. The proportion of clients who have terminated treatment against the caseworker's advice is remarkably low, far less than 15 percent. In fact, half of the juveniles either have entered or remained in treatment with no coercive court order.

To a great extent, the success of all of our efforts at CHNMC depends on the degree to which we are able to tailor our interventions to the needs of our community. Any assessment of a family in which abuse has occurred must include simultaneous examination of the professional, institutional, and community resources and responses that impact on that family. It is not sufficient to look simply at "intrafamily" functioning in cases of child maltreatment. Rather, it is imperative to examine the ecology of the family's living environment and the impact of external stressors upon the family's viability.

Most of the families served by the division of child protection, due to their low socioeconomic and minority status, experience multiple problems. Thus, the crisis of child maltreatment is often intertwined with other critical issues such as unemployment, poor housing, severe familial medical problems, and internal family conflicts. Treatment of the multiproblem family represents a distinct challenge to the clinical worker and requires some unique extensions of traditional therapeutic practices.

For example, while one traditional goal of intervention with an abusive parent is to assist in the development of skills for handling stress, with multiproblem families, it is also necessary to provide practical assistance to help solve some of the family's immediate survival problems, such as assisting in obtaining appropriate benefits from various entitlement programs.

Similarly, flexibility in scheduling appointments is often indicated. A client's late arrival or failure to keep an appointment should not be assumed to be an indication of "resistance to therapy," but should be seen in light of other factors, such as lack of transportation or difficulty in arranging for child care.

It is most important that the worker indicate that he or she: one, understands the pressures that the client must contend with and is willing to meet the client halfway; and two, cares about the client's total well-being.

A second critical area is that of cultural and ethnic value systems, an area which inevitably has important implications for assessment and treatment. This is a highly complex topic but a few main points can be made. The value system of the clinician is shaped by his or her own experiences. Thus, a clinician is likely to have difficulty accepting a cultural perspective which does not "fit" his or her own. Similarly, he or she will have to work to gain an adequate understanding of the impact of personal or institutional racism as contributing ecologic catalysts in abuse cases. We recommend that the clinician consciously articulate any discrepancy in value orientation between himself/herself and the client.

The clinician should actively seek the familial and cultural strengths that are presented by the family, rather than dwelling on the perceived familial or community deficits. An extended kinship system or a strong church affiliation, for example, should be recognized as very important external supports that can and should be incorporated into the plan for addressing the targeted clinical problem.

I could provide a number of other examples of the work being carried out at CHNMC to prevent child abuse and neglect—initiatives in our Child Life Program, our newborn intensive care nursery, our outpatient department, our department of social work, and many more. I hope, however, that the examples I have already outlined will serve to illustrate the multifaceted role hospitals can and should play in prevention. The keys, I believe, are:

One, to establish a core of expertise, such as we have developed through our division of child protection; two, to integrate preventive strategies into the full range of other hospital services—for example, teaching parenting skills during routine well child visits, training staff to recognize and manage early indications of families at risk; three, to conduct planned and structured outreach efforts to raise public awareness about the problem, how to prevent it and where and how help can be obtained; and four, to plan for and carry out all services and interventions so that they are sensitive and responsive to the needs, values, and culture of the communities served.

In these ways, hospitals can truly serve as gatekeepers for the prevention of child abuse and neglect—as long as they remember always to keep the gate open with communications flowing both ways.

Parenthetically, I see this committee as having a very important role as a focal point in Congress for identifying targets of opportunity for Federal legislation, Federal initiatives, and support of appropriations needed to make the lives of all children much better. Through your investigations and hearings such as these, you will give a far greater insight into the appropriate Federal role in behalf of vulnerable children. I do hope your committee will continue to avail itself of this opportunity.

Mr. ANTHONY. Thank you very much, Dr. Green.

[Prepared statement of Dr. Frederick Green follows:]

PREPARED STATEMENT OF FREDERICK C. GREEN, M.D., ASSOCIATE DIRECTOR, CHILDREN'S HOSPITAL NATIONAL MEDICAL CENTER, WASHINGTON, DC

HOSPITAL-BASED INITIATIVES FOR THE PREVENTION OF CHILD ABUSE AND NEGLECT

Good morning. I am Dr. Frederick Green, Associate Director of Children's Hospital National Medical Center (CHNMC) in Washington, D.C. I also serve as Chairman of the hospital's Department of Ambulatory Medicine and Director of its Office of Child Health Advocacy. I am pleased and honored to have this opportunity to testify before the Select Committee on Children, Youth, and Families about a subject that has deeply concerned me throughout my professional career—preventing the wastage of children that is caused by abuse and neglect.

Hospitals have been called "gatekeepers" for the identification of child abuse and neglect. That is, sooner or later, child victims usually are brought to a hospital—to an emergency room if their condition is acute, or to some other department if their problem is less immediately threatening to life or limb. When this happens, specially trained and highly skilled health professionals will be able to diagnose the clinical symptoms and initiate appropriate interventions. This is a vital aspect of hospital services, but it is by no means the only services hospitals can provide for children at-risk of maltreatment: Hospitals can also be gatekeepers for the prevention of child abuse and neglect.

At CHNMC, preventive efforts are focused in the Office of Child Health Advocacy (OCHA). This office was established in 1973 as a concrete expression of the hospital's commitment to meeting the needs of the "whole child" by going beyond the walls of the institution to join forces with the community we serve. As further reflection of this commitment, OCHA has been placed sufficiently high in the hospital's administrative and management structure to ensure that it has adequate purview to accomplish its mission.

In the broadest sense, child health advocacy, as practiced by OCHA, is a discipline that recognizes and seeks to compensate for the fundamental vulnerability and powerlessness of children. It is a series of planned and systematic "interventions on behalf of children in relation to those services and institutions that impinge on their lives" (Kahn, 1973).

As a working philosophy, OCHA's efforts are based on the premise that children have a right to good health. In practical terms, this orientation translates into advocacy initiatives directed toward ensuring that there are sufficient available and accessible services to prevent the onset of health and developmental problems (i.e., primary prevention) or, failing that, to prevent the progression of problems and minimize their ill effects (i.e., secondary prevention). Our basic tools are outreach, education, coalition building, information sharing, and, of course, analysis, research, and evaluation.

Over the past decade, OCHA has put advocacy to work for children with substantial success in a number of areas. Through the efforts of our Committee for Lead Elimination Action, a city-wide, lead poisoning prevention consortium coordinated by OCHA, the rate of lead toxicity in our city has declined from 32 percent in 1973 to less than one percent today. Through our Sudden Infant Death Syndrome Information and Education Project, we are working to prevent the devastation that so frequently afflicts families when a SIDS death occurs. Through our Women, Infants, and Children Supplemental Foods Program, we are helping to prevent infant death and disability among low income community families.

Primary prevention is the principal mission of OCHA's largest outreach arm, the Comprehensive Health Care Program. Through this program's two neighborhood clinics, we have been able to offer thousands of the District of Columbia's neediest children the primary, preventive health care that is their due and their entitlement. This care is essential in ensuring the early identification of children and families at-risk for abuse or neglect. It also provides us with continuing opportunities for educational interactions with parents, helping them understand normal child development and develop realistic expectations for their children's capabilities and behavior.

OCHA also has carried its prevention efforts into the D.C. Public Schools. The School Health Project, established in 1981, involves medical students from George Washington University in educational outreach with District junior and senior high school students. Over 100 medical students and 500 school children have now particpated in the program, which has the goals of:

Providing young people with the information they need to make informed decisions about their own health and well-being and that of their children or future children; and providing physicians-in-training with community health knowledge, skills, and experience.

The common denominator of all these programs, as well as others under the OCHA umbrella, is prevention tailored to community needs.

Our efforts specifically on behalf of abused and neglected children provide a classic illustration of advocacy in action to protect child health. These efforts began in the early 1970s when an informal, multidisciplinary group of clinicians undertook supervision of the treatment of most of the battered and neglected children who presented for care at the hospital. In addition to developing specialized skills in the management of these cases, the group also began working locally and nationally to bring the needs of this vulnerable population to the attention of other service providers and those in policy making positions.

By 1975, we were successful in obtaining funds from the National Center on Child Abuse and Neglect to establish a national demonstration project which we called the Child Protection Center. This effort was expanded in 1978 when the Law Enforcement Assistance Administration granted us funds for a Special Unit to care for child victims of sexual abuse. A reorganization of these programs in 1982 brought both staffs together into a single administrative unit called the Division of Child Protection. The original grant funds have long since expired, and the Division is currently struggling to maintain its fiscal balance with a precarious combination of Medicaid and other third party reimbursements, hospital support, and a patchwork to relatively small public and private grants and contracts.

Still, today the multidisciplinary staff of 16 includes social workers, clinical psychologists, nurse clinicians, and physicians, as well as several consulting psychiatrists, who are involved in the day-to-day delivery of care. The Division has maintained a clinical approach based on two separate treatment teams, since there are considerable differences in the kinds of interventions needed in case of physical abuse or neglect and those required in cases of sexual abuse. The teams provide 24-hour, on-call coverage in the Emergency Room and deliver a full range of crisis intervention, therapeutic, consultative, and rehabilitative services. A variety of treatment modes are available to the victimized child and family, including psychiatric and psychological evaluation, individual therapy for parents, individual counseling and/or play therapy for the child, group counseling, and social service assistance.

In 1983, the Divisions' clinical teams managed over 1,000 cases of child maltreatment. Over 90 percent of the caseload is Black, most reside in the city, and at least 60 percent are low-income. The average age of child victims of physical abuse or neglect is three to five years, while the average age of sexually victimized children is eight to nine years.

The fundamental mission of the Division is to protect individual child victims from reabuse (secondary prevention) and to protect potential victims from harm (primary prevention). The critical pathway to secondary prevention is, of course, the treatment provided to the abused child and his or her family. In cases of battering or neglect, treatment goals may include helping the parent to gain a cognitive understanding of what happened in relation to the abusive incident and what the potential or actual consequences may be; reinforcing the parents' positive or adaptive parenting skills; enhancing the parents ability to recognize and confront stress constructively, etc. The central concern is to maintain the family unit if at all possible and to strengthen it so as to assure the future health and well-being of the child.

The success of the Division's treatment approach in halting the abusive cycle has been amply demonstrated. Recidivism, i.e., repeated incidents of abuse of a child, occurs in less than eight percent of validated cases. This is a striking finding when one considers that the research literature reports recidivism in about 50 percent of cases of child abuse in which no intervention is made.

In addition to its extensive case management responsibilities, the Division also carries out research, organizes and implements a wide variety of professional and community education programs, and provides legal support services, such as court accompaniment. With specific reference to prevention programs, three Division initiatives stand out, and I would like to describe each briefly.

PARENTING SKILLS EDUCATION PROGRAM

The Division's Parenting Skills Education Program provides the District with a valuable resource that meets the needs both of parents and of other providers of child abuse and neglect services. The purpose of the program is to offer specific instruction to modify abusive parenting behavior. The program is an adjunct to therapeutic services and is not intended as a substitute for psychotherapy or individual counseling. However, by acquiring new information about child development and parenting techniques and by reassessing attitudes, parents are often able to replace ineffective and abusive practices with healthier childrearing approaches. The objectives of the program are:

To acquaint parents with the normal growth and development patterns of children; To identify alternative disciplinary approaches and techniques necessary for healthy childrearing; and To facilitate management of specific, common childrearing issues.

The program is entirely voluntary, and any parent who is having difficulty managing his or her child is eligible to participate. Referrals are accepted from court social services, protective services, foster care, legal aid, volunteer attorney services, and a number of private agencies.

The eight-week series of classes comprises ten hours of instruction, which concentrate on the years from infancy to age six. Equal emphasis is placed on material concerning growth and development and that addressing behavioral management of children. Instructional methods include lectures, films handouts, small group discussions, homework assignments, role modeling, and demonstrations.

In addition to knowledge gain (which is measured through a pre-test/post-test design), the classes also have therapeutic value. Parents receive group support when they engage in class activities, an especially important benefit for abusive parents who tend to be isolated and to lack informal support networks. Over 75 parents have taken the course, earning Certificates of Completion which provide concrete evidence and reinforcement of their achievement.

SCHOOL-BASED SEXUAL ABUSE PREVENTION PROGRAM

In spite of the prevalence and seriousness of child sexual abuse, most children receive little or no information about this hazard and are not taught effective techniques for protecting themselves. A child may receive vague warnings about not talking to strangers, but the reason for this prohibition is usually left clouded. Moreover, most children who are sexually victimized are abused by someone they know. Often the offender is a member of the child's family or a close associate of a family member. There is perhaps no other actual or potential danger faced by children that is so completely obscured by parents, educators, health professionals and our society as a whole.

The Division's School-Based Sexual Abuse Prevention Program is designed to address this issue. Its purpose is to help children understand what is meant by sexual abuse, teach them ways to protect themselves from being abused, and acquaint them with sources of help if they are being abused, have been abused, or are abused in the future.

It is also intended to educate parents about the nature and extent of sexual abuse, ways in which they can protect their children, and where they can get help if abuse occurs. Finally, the program is designed to train school personnel in the identification and reporting of abuse, as well as in getting assistance for abused children who come in their attention.

The program is now in its third year, working with third and fourth grade students, parents, and educators in four District elementary schools. The curriculum for the program is currently being refined and evaluated, with the goal of disseminating it as a model for replication in other urban school systems.

JUVENILE ABUSER TREATMENT PROGRAM

While the two program components discussed above are directed toward primary prevention, the Division also stresses secondary prevention as is exemplified in the Juvenile Abuser Treatment Program. This program, initiated in 1981 with grant funds from the National Center on Child Abuse and Neglect, provides both short- and long-term outpatient treatment for adolescents who sexually molest younger children. The program functions as both a pre- and post-adjudication diversionary placement for the juvenile justice systems in the District of Columbia and surrounding jurisdictions. It is the only specialized treatment program for juvenile sexual offenders in the Washington Metropolitan Area, and, to our knowledge, one of only a handful of such programs nationwide.

The JATP was established as a result of the growing awareness on the part of Division staff about the magnitude of the problem of sexual abuse by adolescents. Of the 1,600 cases of such abuse known to the Division, 47 percent involved juvenile offenders, with over 32 percent of these involving family members.

Regardless of the offender's familial relationship to the victim, these abusive incidents usually have negative psychological and social consequences for the victimized child, the adolescent abuser, and the family members of both the victim and offender. Moreover, current research findings indicate that most adult sexual offenders begin their sexually assaultive behavior during adolescence, usually victimizing younger children. Quite simply, current research and treatment findings suggest that the adolescent sexual abuser of today, if untreated, is likely to be the adult sexual offender of tomorrow. Yet, despite the prevalence and seriousness of this problem, little is known about its etilogy or the most efficacious treatment of juvenile sexual abusers and their families.

JATP seeks to develop, evaluate and ultimately disseminate a specialized model for effective intervention and treatment of the juvenile sexual abuser. This treatment model is designed to:

Enhance family stability by reducing the frequency with which either juvenile abusers or their victims are removed or expelled from the home;

Demonstrate success in cognitive restructuring and behavioral modification of juvenile abusers in areas related to their abusive behavior;

Provide sufficient flexibility and comprehensiveness to be accessible to the majority of juvenile offenders; and

Be cost-effective when compared to alternative approaches (e.g., incarceration, individual traditional psychoanalytic psychotherapy, etc.)

The JATP model consists of a diversionary process which allows juvenile abusers to enter treatment as soon as possible following disclosure, even while legal proceedings are continuing. Treatment consists of individual psychotherapy for the abuser; and, in interfamily cases, individual counseling for the parents and the child victim, and family therapy for the family unit as a whole.

Although it is too early to speak of conclusive findings, preliminary program data and clinical observations are encouraging. To date, there has been no identified recidivism by the adolescents who have entered treatment. The proportion of clients who have terminated treatment against the caseworker's advice is remarkably low, far less than 15 percent. In fact, half of the juveniles either have entered or remained in treatment with no coercive court order.

We believe the JATP is of critical local and national significance. Locally, it serves as the only existing diversionary and treatment resource for the District of Columbia and for adjacent jurisdictions of Maryland and Virginia. Nationally, it holds the promise of providing a model for treatment and intervention in an area that virtually has been ignored in the past.

To a great extent, the success of all of our efforts at CHNMC depends on the degree to which we are able to tailor our interventions to the needs of our community. Any assessment of a family in which abuse has occurred must include simultaneous examination of the professional, institutional, and community resources and responses that impact on that family. It is not sufficient to look simply at "intrafamily" functioning in cases of child maltreatment. Rather, it is imperative to examine the ecology of the family's living environment and the impact of external stressors upon the family's viability.

Most of the families served by the Division of Child Protection, due to their low socio-economic and minority status, experience multiple problems. Thus, the crisis of child maltreatment is often intertwined with other critical issues, such as unemployment, poor housing, severe familial medical problems, and internal family conflicts. Treatment of the multi-problem family represents a distinct challenge to the clinical worker and requires some unique extensions of traditional therapeutic practices.

For example, while one traditional goal of intervention with an abusive parent is to assist in the development of skills for handling stress with multi-problem families, it is also necessary to provide practical assistance to help solve some of the family's immediate survival problems; such as assisting in obtaining appropriate benefits from various entitlement programs.

Similarly, flexibility in scheduling appointments is often indicated. A client's late arrival or failure to keep an appointment should not be assumed to be an indication of "resistance to therapy," but should be seen in light of the other factors, such as lack of transportation or difficulty in arranging for child care.

It is most important that the worker indicate that he or she (1) understands the pressures that the client must contend with and is willing to meet the client halfway, and (2) cares about the client's total well-being.

A second critical area is that of cultural and ethnic value systems, an area which inevitably has important implications for assessment and treatment. This is a highly complex topic, but, rather, a few main points can be made. The value system of the clinician is shaped by his or her own experiences. Thus, a clinician is likely to have difficulty accepting a cultural perspective which does not "fit" his or her own. Similarly, he or she will have to work to gain an adequate understanding of the impact of personal or institutional racism as contributing ecologic catalysts in abuse cases. We recommend that the clinician *consciously articulate* any discrepancy in value orientation between himself/herself and the client. Further, it is important for the clinician to practice reversing roles in an attempt to gain better understanding of the value issues that arise in a given clinical situation and their potential impact on the treatment approach.

The clinican should actively seek the familial and cultural strengths that are presented by the family, rather than dwelling on the perceived familial or community deficits. An extended kinship system or a strong church affiliation, for example, should be recognized as very important external supports that can and should be incorporated into the plan for addressing the targeted clinical problem.

Finally, the utilization of multidisciplinary and interracial team reviews of treatment plans is one of the best ways of assuring appropriate and effective interventions. Peer review and supervision are critical vehicles for identifying missed cues, inappropriate interpretations, or counter-transferences.

I could provide a number of other examples of the work being carried out at CHNMC to prevent child abuse and neglect—initiatives in our Child Life Program, our Newborn Intensive Care Nursery, our Outpatient Department, our Department of Social Work, and many more. I hope, however, that the examples I have already outlined will serve to illustrate the multifaceted role hospitals can and should play in prevention. The keys, I believe, are:

1. To establish a core of expertise, such as we have developed through our Division of Child Protection.
2. To integrate preventive strategies into the full range of other hospital services (e.g., teaching parenting skills during routine well-child visits, training staff to recognize and manage the early indications of families at risk of abuse).
3. To conduct planned and structured outreach efforts to raise public awareness about the problem, how to prevent it, and where and how help can be obtained.
4. To plan and carry out all services and interventions so that they are sensitive and responsive to the needs, values, and culture of the community served.

In these ways, hospitals can truly serve as gatekeepers for the prevention of child abuse and neglect—as long as they remember always to keep the gate open, with communications flowing both ways.

Mr. ANTHONY. Dr. Whitworth.

STATEMENT OF J.M. WHITWORTH, M.D., ASSOCIATE PROFESSOR OF PEDIATRICS IN CHILD ABUSE AND NEGLECT, UNIVERSITY OF FLORIDA, EXECUTIVE MEDICAL DIRECTOR, CHILDREN'S CRISIS CENTER, CONSULTANT TO FLORIDA STATE DEPARTMENT OF HEALTH AND REHABILITATIVE SERVICES IN CHILD ABUSE AND NEGLECT

Dr. WHITWORTH. I will be extremely brief.

Mr. ANTHONY. It looks like you are running for President with all those microphones.

Dr. WHITWORTH. I don't think so yet. The committee has detailed statistics as to materials I am going to be presenting. I will refer you to those and will abstract as much as I can as I go along.

My name is J.M. Whitworth, M.D. I am associate professor of pediatrics in child abuse and neglect at the University of Florida and consultant at the Florida State Department of Health and Rehabilitative Services in Child Abuse and Neglect. My purpose is to briefly summarize for you what is going on in prevention of child abuse in the State of Florida.

Initially I had intended to build an argument that child abuse was a major problem in the United States, and also in the State of Florida. But other speakers before me have done that very effectively, and I will not repeat that data except to say that one of the factors that I believe was highly responsible for passage of recent legislation in the State of Florida were statistics that related to the relationship between juvenile delinquency and the history of child abuse in the family. At least 50 percent of families reported for abuse or neglect had at least one child later taken to court as delinquent or ungovernable. Among these delinquents they were 58 times more likely to commit rape than their control counterparts.

As has been mentioned before, in sexual abuse, sexually active and promiscuous teenage girls gave a history of sexual victimization in at least 80 percent of the cases studied. Florida has a history of having developed an effective statewide network of child-protection teams which are multidisciplinary teams, primarily operating after the fact. And therefore, subsequently an attempt was made to develop legislation which would address the issue of prevention directly.

This legislation was introduced by Representative John L. Mills; a companion bill was introduced by Senator Robert McKnight and became law in the State of Florida on March 20, 1982, becoming chapter 82–62, Laws of Florida. This bill, then law, introduced the concept of a statewide Task Force for Child Abuse Prevention, as well as creating district task forces in each of the HRS districts within the State. These task forces were given certain mandates. Statewide activities of the task force included a program to provide instruction to all school personnel on a statewide basis.

The second major emphasis was on education of all law enforcement personnel on a statewide basis. The third was statewide involvement in an extensive ongoing public awareness program conducted jointly by the public information, office of the secretary, and also the child protection Teams throughout the State. All three of these components are now in place and are now active in the State of Florida.

There are a total of 26 individual projects which have been selected by district task forces to be implemented throughout the State. Those are summarized in the materials that have been provided to you. I will not detail them individually except to talk in terms of generalities as far as types of programs. One type of program is a prenatal-and perinatal-support-services program, very similar to some of those which you have heard described to you today, and also in previous testimony. Within the prenatal services component, the program was made available to all prenatal clinics in the district in which it was implemented. This particular component was primarily an educational component as well as identifying those high-risk individuals coming into prenatal clinics who could receive certain supportive activity such as group-therapy sessions, specific educational sessions as far as parenting is concerned, then to enter into a perinatal-services component in which we provide labor coaches from a cadre of volunteers.

Subsequent to that the individuals go into our postnatal program, which provides home health visitors who actively are involved in neonatal and perinatal stimulation of the infants as well as the general education program and group activities for the adults involved.

This particular program has increased significantly parental knowledge about the needs of children in developmental stages, has decreased family isolation and increased peer support. Has increased an appropriate utilization of social and health services and also increased parental knowledge about household management. We have been particularly concerned about sexual-abuse prevention activities in the State of Florida, as has been mentioned to you, at least parenthetically, sexual abuse has always been thought to be preventable by talking in terms of the dirty old man or the individual riding in the car asking the child to get in. As we know, we are talking in terms of possibly as much as 20 percent of sexual abuse when we try to prevent it by talking to our children in those terms; 80 percent, on the other hand, is committed by individuals who are very well known to the child, and therefore would be totally left out from any program that approached it in that way. Therefore, we are currently in school systems in several districts in the State of Florida providing a good-touch-bad-touch program for children in kindergarten through second grade. This has, again as was noted by previous individuals, been very effective in changing concepts children have of their ability to say no and their ability to protect themselves against what they then perceive as bad touch.

The concept of a crisis nursery has been very adequately spoken to in previous testimony. There are three crisis nurseries currently in place in the State of Florida, and are working very effectively as a place where a parent can find respite when it is needed. Until recently the entire approach of funding the problem of child abuse was spent in identifying, diagnosing, and treating after the fact.

I hope it is not confusing to the committee or anyone else who hears testimony on prevention of child abuse in that there seem to be a variety of ways that are effective. That in fact is true. There is no one single answer. Those of us who have worked in the field and are involved in the field become more and more acutely aware of the fact that it is necessary to fund a variety of kinds of programs because they all have some direct effect on family function and therefore have some direct effect on child abuse as a problem.

First, we would suggest from the standpoint of potential legislation and funding would be one to reserve funding primarily for service programs which provide direct service to the largest populations possible such as perinatal, prenatal, and postnatal programs.

Second, fund services with heavy emphasis on utilization of trained volunteers for the service provision as this has been shown to be extraordinarily effective with abusive families.

Third, preferential funding for programs which reach a large population on a longitudinal basis, that is parenting programs in schools, newborn, and pediatric agencies.

Fourth, fund programs which provide evaluation systems for measurable effectiveness in changing attitudes and behavior and measurement of educational objectives.

Most importantly, we would suggest an absoute commitment to the health and safety of our children by fostering any effort which would elevate them to first priority status.

[Prepared statement of Dr. J. M. Whitworth follows:]

PREPARED STATEMENT OF J. M. WHITWORTH, M.D., ASSOCIATE PROFESSOR OF PEDIATRICS, CHILD ABUSE AND NEGLECT, UNIVERSITY OF FLORIDA, EXECUTIVE MEDICAL DIRECTOR, CHILDRENS CRISIS CENTER, INC., CONSULTANT, STATEWIDE CHILD PROTECTION TEAMS PROGRAM, CHILDREN'S MEDICAL SERVICES, JACKSONVILLE, FLA.

CHILD ABUSE PREVENTION IN THE STATE OF FLORIDA

Introduction

According to national child welfare statistics, it is estimated that over one million children are physically abused, sexually abused, neglected or emotionally maltreated each year in the United States, with an estimated two thousand children dying each year from abuse and neglect. The problem outranks any disease as a prime killer of children. Mortality statistics are not only highly significant, but also frightening. If morbidity statistics are added, the magnitude of the problem as a public health issue is this country is brought into perspective. Those who survive abuse are estimated to have at least a 30 percent chance of permanent physical or phychological sequelae.

Child abuse rates are increasing nationwide. In a fifty state survey completed by the National Committee on Prevention of Child Abuse in November 1983, forty-five states indicated that reports of child abuse increased. Thirty-eight states said that the types of cases being reported were becoming more serious. A similar survey completed by the National center earlier in 1983 showed the number of deaths due to child abuse increasing by an average of forty-four percent in over half the states reporting.

If health issues are not enough to speak to the need for child abuse prevention programs, we can look to statistics which relate the problem to a variety of other serious social problems. In the Source Book of Criminal Justice Statistics, published in 1981, it was noted in a study by Welch that ninety-seven percent of hard-core delinquents experienced a history of severe physical punishment and assault in their home. In another study, it was noted by the New York State Assembly Select Committee on Child Abuse in 1978 that fifty percent of families reported for abuse or neglect had at least one child later taken to court as delinquent or ungovernable. It was noted among other findings that these delinquents were fifty-eight times more likely to commit rape than their control counter-parts. As a footnote it should be mentioned that in 1979 the Federal Government spent $398 million dollars in correctional costs in addition to the $300 million spent by states for this purpose. It should be noted that in the same study in one-third of all New York homicides a history of childhood abuse in the perpetrator's background is present. Others have noted that two-thirds of prisoners convicted of first degree murder report previous childhood histories of physical brutality. In the study done by Benward Denson-Gurber in 1975, it was noted that female teenage prostitutes gave a history of sexual victimization as younger children in eighty percent of the cases studied.

Physical abuse or neglect is a significant cause of long-term mental retardation and developmental delay in a multitude of studies done in the past several years and also is a prominent cause of cerebral palsy developing subsequent to the newborn period. Knowing the tremendous costs of institutionalization and special education for the groups mentioned above, one should have no great difficulty in making a significant case for prevention of child abuse from the human standpoint, as well as the potentially tremendous savings in the costs treatment or institutionalization.

When child abuse reporting laws were written across the country, the emphasis was initially on developing systems for crisis intervention for abused and neglected children. Although this intervention system was much needed, it was only a very short time until those involved in the field were very much aware of the fact that these programs in general offered no prevention component and continuously operated "after the fact". At best, there was prevention of reabuse in a single family. There emerged the realization of a tremendous need to develop prevention programs which could benefit a larger population at risk. In studies done by Helfer and others to attempt to identify the populaton at risk, it became quickly apparent that prevention programs should educate the population as a whole to be maximally effective and to provide the greatest possibility of change in society's attitude toward children and their place in society.

Development of child abuse networking in the State of Florida

The State of Florida has enacted legislation dealing with child abuse beginning in 1901 and additionally in 1923, 1965, 1971, 1974, and 1975. The legislation in 1975, which is currently Chapter 827 Florida Statutes, provided for mandatory reporting of suspected child abuse and delineated responsibilities for public agencies including establishing a statewide abuse registry and providing for confidentiality of reports and records. This Statute has been amended on a number of occasions since that time.

Florida already had a record of successful statewide networking in the development of the Child Protection Teams program. (See Appendix A.)

In December of 1981, a Bill was filed in the Florida House of Representatives as House Bill 296 by Representative Jon L. Mills (Democrat—Gainesville), an act relating to the prevention of child abuse and neglect. House Bill 296 required the Florida Department of Health and Rehabilitative Services to develop a comprehensive state plan for the prevention of child abuse and neglect to be submitted to the Governor, the President of the Senate, and the Speaker of the House on January 1, 1983. The Bill created an Interprogram Task Force which required participation by the Department of Education and local agencies and organizations, as well as provided for specific duties of the Task Force. The Department of Health and Rehabilitative Services and the Department of Education were additionally mandated to develop methods of instruction for public school personnel in the detection of child abuse and neglect and to develop curricula on child abuse and neglect. The bill required the Florida Department of Law Enforcement and the Department of Health and Rehabilitative Services to jointly develop ways of informing and instructing appropriate law enforcement personnel in the detection of child abuse and neglect, and the appropriate methods of handling suspected cases. The Department of H.R.S. was further required to educate the general public regarding child abuse and neglect. Each district of the Department of Health and Rehabilitative Services, which comprises eleven districts geographically distributed throughout the State, was mandated to develop a district plan and to establish a District Task Force. The format for district plans was provided for in the Bill. An appropriation of one million one hundred thousand dollars was initially included for the implementation of the act. The Bill further provided that all future appropriations for child abuse and neglect prevention efforts be based on the State plan. A Companion Bill, Senate Bill 737, was filed by Senator Robert McKnight (Democrat—Miami) for consideration in the Senate. Both Bills passed without amendment on March 9, 1982, and the Bill was signed into law by Governor Bob Graham on March 20, 1982, and became Chapter 82-62 Laws of Florida.

The State Task Force was convened subsequent to the passage of the Bill and published a state plan for comprehensive approach to the prevention of child abuse and neglect in Florida in December 1982 with provisions this plan be updated every two years. In the report, guidelines for creation of District Task Forces were clearly delineated. These Task Forces were made up of a broad representation of the community representing all agencies who had direct or indirect contact with abused and neglected children, and who might have the capability of providing expert input as to development of prevention programs in the area. These District Task Forces, through a series of meetings, were able to identify a variety of local needs, and at the culmination of needs assessment, requested proposals from vendors for allocation of funds. Allocations were subsequently made and programs implemented. These programs have been in operation for varying but limited lengths of time, and therefore, definitive results as to direct effectiveness have not yet been assessed. However, there is at least available anecdotal data for each program.

Description of representative prevention programs

Three statewide activities were described in the goals and objectives of the State Task Force on Child Abuse and Prevention. As of June 1, 1983, all had been begun and were well on the way to meeting the requirements of the statute.

The first of these was a program to provide instruction to all school personnel statewide. The Task Force developed the three year time table for such training to occur, and by June 1, 1983, the staff of the Department of Health and Rehabilitative Services and the Child Protection Teams System were able to provide relevant training to elementary school personnel. The plan included providing similar training to middle school personnel in the second year (currently in process), and during the third year, high school personnel are to be trained under a curriculum already developed.

The second major emphasis was on education of law enforcement personnel. Instructional objectives and curricula for a two hour presentation on the topic were developed and were submitted to all training centers by the Florida Department of Law Enforcement. This curriculum has been included in an eight hour block of instruction on "crimes against persons" and in general, has been provided by the Child Protection Team personnel in each district. In addition, the same training provided on video-tape is offered to new employees and periodically used for in-service training.

The third area of statewide involvement was an extensive on-going public awareness campaign conducted jointly by the Public Information Office of the Secretary of Health and Rehabilitative Services and also the Child Protection Teams throughout the State. This campaign included television spots, and printed pamphlets for professionals and lay individuals. These continue to be utilized in an on-going effort to keep statewide awareness at a very high level. It should be noted that many of the District Task Forces have identified this as a priority item and have utilized local funds for this purpose.

In the interest of brevity, I have selected three programs which demonstrate many components which are common to all prevention programs in the various districts in the State. A brief description of all other programs in the State is provided as Appendix B.

Prenatal and perinatal support services

The contention of this project is that by early identification and a program of intervention, risk factors can be decreased or even minimized for a more nearly optimal bonding process, resulting in a decrease in maladaptive behaviors including child abuse. The importance of a continuum of services cannot be over-emphasized since constancy of input with specialized services at key times seems absolutely necessary for a positive effect. This program brings together the existing knowledge in improvement of family systems by a variety of mechanisms and agencies to help at various times during the prenatal, perinatal and postnatal period with primary focus on the mother-infant diad, but with real and measurable effects on the total family unit.

The program is operated by the Children's Crisis Center, Inc. which is physically located at University Hospital of Jacksonville. As an independent non-profit agency primarily operating with state funds which are provided through the Children's Medical Services system, it was possible for the purposes of this project to affiliate with the Division of Neonatology of the Department of Pediatrics at University Hospital, the Department of Obstetrics and Gynecology, and the Public Health Department which provide the services of the nurse-midwife team in prenatal and perinatal care on a district wide basis. The Neonatology Division is responsible for overall care of the Neonatal Nurseries in every major hospital in Jacksonville, and therefore, has access to a referral population which is truly community-wide. The marriage of these groups provided access to the pre-term patient, providing potential for continuity throughout the delivery and post-delivery period through clinics and hospital visits, and then provided expertise in the area of child abuse and neglect allowing a unique potential for longitudinal contact with and impact on high risk parents. These groups and University Hospital provide nearly all of the indigent care in the immediate area and are in contact with the highest risk population present in the geographical area. This fact provided a unique opportunity to develop a program which could specifically address the needs of high risk parent longitudinally beginning as early as possible before delivery and continuing as long as needed. It also provided the opportunity to coordinate the many already existent medical and para-medical programs which could be effectively utilized to assist these parents. All participants in this program had already addressed the prevention issue to a certain extent, but all were unable to increase the intensity of that commitment because of funding and personnel limitations. On the other hand, since some existing capabilities were present, a relatively modest increase in funding resulted in a much broader effect on the population served. It is strongly felt that in the population we serve there is a need to not only effectively coordinate programs dealing with parenting, but more specifically to address broader concepts of family systems. Family systems include all of those activities which have a direct relationship to the interaction between the infant and parent (mother, surrogate mother and father figure) and also an overall understanding of the multiple processes which takes place surrounding the birth of the baby and the concomitant experiences which can be anticipated. This is a much more complex issue than parenting skills. We envisioned the beginning of the continuum as an educational process utilized in prenatal clinics, and in addition, by referral from the various agencies in the community which deal with high risk parents.

The services provided by the Prenatal and Perinatal Support Services to High Risk Families and Children (PPSS) are under the direction of a Program Director and Family Systems Coordinator with assistance by clerical and volunteer staff. The services provided are in three basic categories:

1. *Prenatal Services Component.*—The program identified all existing prenatal services being provided through the Perinatology Program and Nurse-Midwifery Program based at University Hospital, as well as the Public Health Department. The program made available to all prenatal clinics printed material which described the programs available to parents, the importance of family life activities and improvement of parenting skills. These written materials made it possible for clients to access the program directly without referral, if desired. In addition, a video-tape presentation was presented in waiting areas at various selected prenatal clinics throughout the community. The presentation utilized a discussion format regarding questions of parenting, the perinatal period in general, the phenomenon of bonding, and addressed some of the feelings common to parents facing that period and the support systems needed by them. In addition, during the prenatal period, a high risk check list was completed by professionals seeing patients in prenatal clinics and referral to the program was made of those "at risk" individuals for more intensive involvement. Parent support groups were developed during the prenatal period to provide a forum for individuals to discuss problems of common concern and to begin to prepare for the stresses of delivery and immediate post-delivery adjustment. Coordination and development of these services required that the Family Systems Coordinator make visits to many of the prenatal clinics to describe the program and also to facilitate the process of initial intake. Intake was also facilitated from other programs providing services to prenatal clients which may include literature being available at Food Stamp Offices and other public welfare agency offices.

2. *Perinatal services component.*—Individuals entering this component are those who have already been identified and established as high risk individuals and also intake of clients who have had no prenatal care, but who are felt, at the time of admission to the hospital, to potentially derive significant benefit from input by the program. These include individuals who are known to be of high risk because of the assessment tool or also a significant number who are defined as high risk simply because they had no prenatal care. Those services offered during this period of time are the assistance of a labor coach from a cadre of volunteers. These individuals are trained in techniques of parental support during the labor period, enhancement of bonding and follow-up care during the immediate post-partum period. Individuals who are especially eligible for the labor coach program are those who have no significant other person to help support them through this period. Intermediate post-partum period parent classes are offered to improve immediate parenting skills, as well as facilitate the bonding process on a group basis. All participants in the program are visited periodically by the Family Systems Coordinator to assist in identifying both immediate and future needs.

3. *Postnatal services component.*—Those clients desiring continued contact are encouraged to go into the postnatal program which includes such services as the Home Health Visitor, developed from a cadre of volunteers and trained by the program. These individuals are trained as facilitators for continued bonding activity, as well as a very practical day to day support in the needs of high risk parents with significant financial difficulties. Support is offered in areas of child development, nutrition, budgeting and other similar areas by the Home Health Visitor. As is well known in this community, the Visiting Nurses Association provides a very effective Homemaker Program which provides support for parents not only at the post-partum period, but also later for more specific parental role problems. This portion of the program is intended to expand the role rather than supplant it. Trained Visiting Nurses Association Homemakers are a logical training and supervision resource for Home Health Visitors and may be also a logical source of support logistically for the entire Home Health Visitor Component. Coordination continues at this point with other agencies in the community, and if the client is appropriate, for example, referral to an existing parenting program or parenting education group takes place at that time. Other referrals such as to Children's Medical Services Clinics for specific medical problems, other psychological services such as the Child Guidance Clinic and facilitation of entry into community day care at the appropriate time takes place during this period. Self support groups of parents continues in the post-partum period for similar purposes as the groups developed in a prenatal period. It is hoped that adequate continuity will be generated so that the population continuing in groups might be very similar to the population in groups in the prenatal period continuing to act as a support system for each other.

The previously described services were implemented from April 1, 1983, to June 30, 1983, under the direction of a Program Director, Family Systems Coordinator, clerical staff and trained volunteer labor coaches and Home Health Visitors. Services are provided on a referral acceptance basis on Monday through Friday, eight hour work day system to coincide with other agencies open at those times such as the City Health Clinics, pediatric and perinatal clinics.

The outcome of the services provided by this program will be: (1) an increase in parental knowledge about the needs of a child and developmental stages; (2) a reduction of family isolation and increase in peer support; (3) an increase in appropriate utilization of social and health services; and (4) an increase in parental knowledge about household management.

We assume that the most significant evaluation of the effectiveness of the program would be to compare those individuals who have participated in the program with a simliar group of patients who had not participated in the program using as the criterion any evidence of referral of the infant for evaluation of abuse and neglect. This could be accomplished by identifying participants and cross referencing names with referrals to the Child Abuse Registry and both the study group and a like control group with comparison of an attack rate for reporting. Evaluation would also be accomplished by periodic feedback on a formal basis from all clients served utilizing a form designed for that purpose by a consultant independent of the program. Client assessment of the value of the programs individually would be sought and an independent critique carved out. Programmatic adjustment would be made accordingly.

To evaluate specific objectives as listed, we will utilize pre and post testing instruments to evaluate parents' knowledge of needs of a child and developmental stages. Family isolation and peer support will be measured by contact records of various program components and peer support will be measured by contact records of various program components and peer support systems provided. Social and health service contact records will be kept and household managment skills will be evaluated by Home Health Visitors as part of routine reports submitted to the Family Systems Coordinator.

Since the inception of this program, 204 families have been served with referrals increasing each month. Although definative data as to outcome have not been granted, there is very significant feedback from participants as to the effectiveness of the various components, and "satisfied" clients have begun to refer their friends for services.

In recent year we have developed a much more clear understanding of the magnitude of the problem of child molestation. It is estimated that some kind of incestuous behavior exists in one in twenty households, roughly one household per residential block (Justice and Justice, 1984). It is further estimated that before the age of eighteen, at least one in five female children will be victimized by sexual assault or an incestuous relationship. Good statistical information is not yet available on the involvement of male children, as reporting of such instances has not kept up with the tremendous increase in reporting for females. One must assume there is a significant population of boys who are similary victimized. On a yearly basis, we, therefore, know that at least one million children are sexually abused in this country. If one deals with the victims of sexual assualt or incest, one very quickly realized the psychological devastation for the victim immediately after the incident. This extends to a large number of individuals who require long-term or even a life time of psychiatric or psychological counseling to allow them to develop at least assemblence of normal interpersonal relationships.

It was once felt adequate to warn our children that they might be hurt by strangers offering candy or a ride in a car, but more recently we have become very acutely aware that at least eighty percent of sexual assaults are perpetrated by individuals who the children know well and who may be close relatives or trusted adults. Therefore, a different system of prevention had to be developed to take into consideration the need for children to protect themselves from sexual assault from any adult. The "good touch-bad touch" approach makes it possible for a child to overcome feelings of threat of harm or getting into trouble if he/she is confronted with a potentially sexual encounter. It also makes it possible for the child to overcome his highly developed trust in the authority of an adult who is manipulating the child to make them accessible to be molested.

Such a program is being utilized in several areas in the State of Florida is centered around a film which is usually shown to kindergarten, first or second graders called "Speak Up! Say No!", produced by Krause House. The filmstrip's main character is a mouse—Penelope Peabody.

For older children, a more age appropriate film is used called "Who Do You Tell?", produced by MTI Teleprograms, Inc. The second film not only addresses sexual assault, but also a somewhat more broad area of problem solving. Presentations are made by trained volunteers in the school itself, and it should be emphasized that the presentation is not couched in sexual terms. Excerpts from the script provided by volunteers follows:

"I'll bet most of you have been told by your mother or father or teacher that you should not talk to strangers or get in a car with a stranger or to take candy from a stranger. Why do you think that is?

(Field answers and respond appropriately.)

The main reason is that someone who wants you to do something that seems funny to you or that your parents have told you not to do, may be trying to hurt you.

Sometimes the person who is trying to get you to do something you feel is not right, may be a friend or someone your parents already know. Like a coach or a neighbor or your friend's father or a cub scout leader.

In the film, do you remember who the person was who tried to get Penelope to do things she did not want to do?

That's right—her Uncle Sid—sometimes the people who might give us a bad touch are related to us or even live with us. What did he try to get Penelope to do?

That's right—to take her clothes off, and to get her to look at pictures that were not very nice.

That was a not okay touch or a bad touch?

Let's talk a minute about good touches and bad touches.

Bad touches can happen to any part of our body--our arms and legs, our face, and our private parts. By private parts, I mean those areas of the body that are covered by your bathing suits.

What if your babysitter asked you to undress so that you could play a special game with him that would be a secret?

Answer: "No, I don't feel like it."

(After your mom and dad get home, be sure to tell them what the sitter said.)

What if someone touches a private part and asks you not to tell because it is a special secret?

Answer: "I would tell another grown-up that I trusted."

We've talked about people that we know giving us bad touches and what to do.

Remember you have the right to say no to someone touching your body in a way that feels wrong to you. There is always another grown-up who can help. Sometimes, when I have talked to other schools there are some boys and girls who have already had a bad touch from someone they trusted. I tell them to let their teacher or school counselor know. If anyone here feels funny about something that happened to you, your teacher knows how to help you.

Remember what Penelope said? Speak up! Say no!

It was of particular interest to us that a group of children who received this training very early in the program were pre-tested and post-tested for behavior under a given set of circumstances. In a group of kindergarten children when asked the question prior to the training process "What would you do if a stranger offered you a ride to school?" response from the pre-test group was that eighty percent would accept such a ride. Utilizing that same group as a control population, the training session was given by different volunteers in different locations and two weeks after the training session, the children were again asked the question. At second contact, seventy-eight percent of the children who were asked indicated they would not accept a ride from a stranger to school and responses to other questions indicated a significantly heightened awareness of "bad touch" and a need of reporting any incident to their parents or teacher.

We feel that this training approach is not only highly beneficial, but also in the long run will reap highly significant benefits in reducing the incidence of both intrafamilial and extrafamilial sexual abuse and assault.

A project in the Miami area has been developed around a "crisis nursery". The concept is simple. If parents in distress have a place to bring their children where respite care can be given and crisis counseling received, stress will be reduced and the likelihood of child abuse will be less. The program allows self-referral and also accepts agency referrals for short-term supportive services. Programs go well beyond those available in regular day care and clearly focuses on therapeutic intervention and short-term training in alternatives coping skills. The project also incorporates a hot-line for stressed parents and children who feel they are in danger. Referral to more long-term facility in the city and follow-up are provided.

Until recently, the entire approach to the problem of child abuse was to fund programs for identifying, diagnosing and treating child abuse cases after the fact. We have spent hundreds of millions of dollars, if not billions of dollars, to this end. Noone could say that this expenditure in funds is inappropriate and some would argue that even those huge sums are inadequate to meet the needs of identified cases and the intensive treatment needed by the families involved. If there were no known effective means for prevention of child abuse, one could understand the lack of attention to funding the logical avenue to solution of the problem. This, however, is not the case. We do know a lot about how to prevent child abuse and there needs to be a national focus and a national commitment to the support of programs which can do so. We have done so in the past with other pediatric diseases and can do so again with child abuse.

In a recent appearance for the Attorney General's Task Force on Family Violence, Ann Harris Cohen, D.P.H., Executive Director of the National Committee for the Prevention of Child Abuse, testified about a three and one-half year study conducted by the Committee on effective approaches to prevention of child abuse and neglect. This study clearly showed that "programs which offer support to new parents, especially around the time of birth, have been significant in diminishing chances of abuse. Educational interventions delivered by supportive volunteers to first time mothers were effective in reducing factors associated with child abuse". It should be noted that many of the programs referenced are programs which are primarily dependent on the use of large numbers of trained volunteers, thereby allowing significant cost-effectiveness.

If we, therefore, know that a variety of types of programs are effective in at least reducing the potential for child abuse, does it not then make good sense for us to do everything we possibly can to foster the continuation of existing programs and to make funds available to develop new programs where none currently exist.

Our recommendations for the funding of such programs would suggest certain guidelines which would insure the provision of services to the largest possible population at risk, as well as providing guidelines for program efficiency.

Legislative recommendations

1. Reserve funding primarily for service programs which provide direct services to the largest population possible, i.e., prenatal, perinatal and post-natal programs.
2. Fund programs with heavy emphasis on utilization of trained volunteers for service provision.
3. Preferential funding for programs which reach a large population on a longitudinal basis, i.e., parenting programs in schools, newborn and pediatric agencies.
4. Fund programs which provide evaluation systems for measurable effectiveness in changing attitudes and behavior and measurement of educational objectives.

Most importantly, we would suggest an absolute commitment to the health and safety of our children by fostering any effect which would elevate them to first priority status.

APPENDIX A.—FLORIDA'S STATEWIDE PROGRAM OF CHILD PROTECTION TEAMS

INTRODUCTION

Over 83,000 children were involved in reports of child abuse and neglect in Florida in 1983. These children were all too frequently victimized not once, but on multiple occasions; first by the abuser at the time of the crime, and again by the community if the child did not receive appropriate help from appropriate agencies. The medical community stands in a critical position to help avoid exploitation because of an understanding of child development and children's issues.

Exploitation at the time of the abuse incident is obvious and the known reasons why a caregiver abuses a child are well documented. If, in addition to the actual abuse or neglect, the child does not receive appropriate mandated services from law enforcement, the medical community, and the social welfare or judicial system, she or he must survive the crisis alone, and actions taken by well-meaning agencies do little to alleviate the situation. This may increase the sense of isolation of the child and divert the sense of blame toward the child rather than the actual perpetrator.

If inappropriate services or follow-up are provided by a community agency after a report is made and the child's safety is not insured, he or she may be in a situation of extreme danger of direct retaliation from the abuser.

Every one of our country's states is trying to deal with the problem of child abuse and neglect. Florida, however, is well along in developing a system which is unique.

A statewide network of medically directed and oriented multidisciplinary Child Protection Teams has been established and funded by the Florida Legislature. The concept of a multidisciplinary team approach to deal with the problem of child abuse and neglect is not new, and in fact, many metropolitan areas of the United States have established such teams. Only Florida, however, has established a statewide network of such teams, funded by the state and coordinated through a state agency.

BACKGROUND

The Florida State Department of Health and Rehabilitative Services (HRS), is the designated state agency dealing with all abuse cases. HRS has nine divisions (program offices) which provide social and health care services to all eligible citizens in the state. Two of these program offices provide services to children and families involved in child abuse. The first is Children, Youth, and Families Program Office (CY&F), and the second is Children's Medical Services Program Office (CMS).

Within the CY&F Program Office are single intake workers who investigate the initial report of child abuse. They may remove the child from the home, immediately if necessary, and seek a court order for extended out of home placement. If the child is placed in foster care, a foster care worker from CY&F receives the case from the single intake worker and supervises the child's care in placement. If the child is returned to his own home with protective supervision, a protective services worker receives the case from the single intake worker and supervises the child's care. All three of these workers—single intake, foster care, and protective services—have primary responsibility for all reported cases of child abuse, from the initial investigation through the final disposition.

Over a period of time it became evident that these workers, especially single intake, were being required to make decisions regarding the abused child which they were not qualified to make. Often, in order to perform a complete investigation of a report of child abuse, a medical and/or psychological evaluation is necessary. These resources were unavailable or required inordinate delays to the CY&F workers, and they were required to make a decision alone even though untrained to do so.

In an attempt to improve services provided to abused and neglected children by the state, the Florida Legislature allocated funds to the Children's Medical Services Program Office to begin the first Child Protection Team. The Team began providing services in September 1978. Due to the success of this pilot project, the CMS Child Protection Team Program has been expanded each year and currently one Team is in place in every major metropolitan area in Florida. Each Team is responsible for providing services to a specific number of counties and now every one of Florida's 67 counties is receiving services from a Child Protection Team. The State Legislature allocated $3.8 million for the operation of this Program for fiscal year 1983–84.

PROGRAM INFORMATION

Each Team functions under the supervision of a pediatric medical director and includes physicians, social workers, nurses, psychologists, psychiatrists, attorneys, and law enforcement liaisons.

Services provided by each Team include: (1) Medical diagnosis, evaluation, and short-term follow-up treatment; (2) Psychological diagnosis, evaluation and short-term counseling; (3) Expert court testimony; (4) Coordination of all community services provided to the victim and his/her family; (5) Coordinated treatment plans from interdisciplinary community service staffings; and (6) Professional training and community education.

These teams have impacted Florida communities in a variety of ways including: advocating development of new services; development of new services; improving services provided by existing agencies; and increasing agency and community awareness of the problem. New horizons are being specifically designed to meet increasing needs. The following programs have been established within existing resources and provide cost-effective services to families at risk or identified problem families.

1. Medical foster care.—The Teams in Jacksonville and St. Petersburg have established medical foster care homes. Children placed in the homes have been abused or neglected to the point of needing hospitalization for medical or surgical treatment. When they no longer require hospitalization but do not have a safe environment to return to, and in addition need continuing specialized health care, they may be placed in a medical foster home. The foster parent is a nurse or has received specialized medical training to meet the health needs of the child placed in her care. Children with such severe medical problems have, in the past, become the responsibility of the medical community. This responsibility included not only treatment of the medical problem, but provision of day to day living space for the child. The medical treatment was provided at the expense of institutionalizing a child through extended hospitalization due to the lack of appropriate placement homes. Such institutionalization often retarded the social, emotional, and physical development of the child. The medical foster care program offers a positive alternative to this form of institutional exploitation of the abused child. Between July 1, 1980 and June 1981, medical foster homes saved $297,000 in hospitalization costs. This is enough money to fund a complete multidisciplinary Child Protection Team for the same period of time.

2. Preschool for sexually abused toddlers.—The Orlando Child Protection Team has developed a preschool for sexually abused toddlers named The Orange Playhouse. The purpose of the program is to develop a positive self-image and to aid the personal and social adjustment of each child. The director of the Orange House is a Child Development Specialist, and a psychologist. A child psychiatrist provides consultation to the staff and does pre and post testing with the children, as well as sexual abuse treatment and prevention program for all abuse. Currently, children between the ages of two and five are transported to the preschool three mornings a week. All of the children are presently in foster care settings. The foster parents are provided support, education and training to help them in working with the children at home since consistency in expectations and behavior management techniques both at home and at school are important for the child.

Several important areas of institutional exploitation are being avoided through the services provided by this program.

First, all of the child's needs are being dealt with in an environment natural for a child in the preschool age range. The child's social, cognitive, emotional and physical developmental needs are being met in a preschool setting with special attention to deficits occurring as a result of the sexual abuse. The environment is secure from intrusion by guests or visitors. The children are allowed to talk about the abuse they have suffered. Art work frequently depicts male genitals as well as violent feelings. The work is accepted, understood and displayed. The children often engage in agressive behavior, use sexually explicit language and openly masturbate. The staff understands the reasons for such behaviors and work with the children to resolve the underlying conflicts. In a "regular" preschool with staff untrained in dealing with sexual abuse, this understanding and acceptance would not be possible.

Second, the staff works closely with the foster parents caring for the children. Consistent behavior management techniques are used at school and at home. The foster parents have an increased understanding of the causes of the behaviors displayed by the children and also feel effective in dealing with these behaviors. As a result, several of the foster parents are requesting to have only sexually abused children placed in their homes. A cadre of well trained surrogate parents are becoming available to work with this special group of children and again further institutional abuse of the child has been avoided.

3. Intrafamily sexual abuse treatment program.—The Jacksonville and Daytona Beach Teams have each developed Intrafamily Sexual Abuse Treatment Programs for the purpose of rehabilitating the offender offering treatment to the victim and supporting the entire family in order to keep the family unit together if appropriate. These programs offer the following services: (a) Individual counseling for mothers, victims, and abusers; (b) Victim play therapy; (c) Pre-adolescent and adolescent victim support groups; (d) Family therapy; (e) Group therapy; and (f) Marital counseling.

The Intrafamily Sexual Abuse Treatment Programs provide an alternative to jailing the offender (usually the father), and disrupting the family unit, often to the point of total family disintegration.

4. Project Thrive.—The Tampa Child Protection Team has a program called Project Thrive which offers services to babies diagnosed as nonorganic failure to thrive. To prevent repeated hospitalization of these babies when they fail to gain weight at home, the Team has enlisted the aid of social work graduate students from the local university. The students make weekly visits to the home and offer support, education and modeling of parenting and feeding skills. To date, Project Thrive has served over fifty babies and their families. The average stay in the Project was 2½ months, all gained weight appropriately, and no baby is known to have been re-hospitalized for failure to thrive. Project Thrive offers a viable and positive alternative to the common scenario of repeated hospitalizations and family disruptions occasioned by lack of appropriate intervention on failure to thrive cases.

TRAINING AND EDUCATION

From the inception of the program, all Teams have organized their efforts to be sure that all school and professional personnel in their districts are offered training.

Each district met with their Superintendent of Education and Principal and received approval to provide training for all teachers on teacher training days. The Jacksonville Team made a thirty minute video-tape which was shown to 5,000 teachers during a mandated training session in October 1981, over the local educational T.V. station. Phone hook-ups to the trainers on the video-tape were available for a question answer session following the viewing. In addition, a resource teacher in each school received four hours of in-depth training and will act as the school liaison between the teachers and the local Single Intake Staff and the CMS Child Protection Team Staff. This training schedule is repeated each two years. Each organized professional organization dealing with children has been contacted for an on-site training session as well.

The Tampa Team has received approval to conduct on-site training for district teachers during an upcoming teacher planning day. They have developed training materials about child abuse and neglect which the teachers may use in the classroom with their students. In this way, all school teachers and professionals in Florida will have received training regarding the dynamics of child abuse and neglect, reporting requirements, and how to access services currently available in their communities. By training to be alert to signs of abuse and neglect and to respond by reporting to the appropriate agency, vital referral resources are being educated and the ongoing exploitation of a child by his caregivers can be stopped.

Over 35,000 people have attended presentations provided by the Teams during the last nine months.

NEW DIRECTIONS

With the completion of the statewide network and the consolidation of the diagnostic and treatment components, the focus of the CMS Child Protection Team Program is expanding. Several of the Teams are seeking funds for research projects in the areas of foster parent training, failure to thrive and bonding homes, as well as sexual abuse treatment and prevention programs for all abuse.

Florida has recently addressed the need for not only coordination of Child Protection Teams, but also a system of statewide continuing training for these Teams. This has been accomplished by appointment of a full-time medical consultant from the State University System to serve in those capacities, but who is also responsible for coordinating efforts of Child Protection Teams and Regional Perinatal Intensive Care Centers for prevention programs. He also is developing curricula for all professional schools in the state in child abuse and neglect, and networking of data systems to provide material for future research and study.

Thirty Apple II microcomputers with videodisc interface have been purchased and will be used to develop computer assisted training packages for staff training and for educational presentations.

Finally, the Florida Legislature has passed the Mills/McKnight Bill which required the development of a statewide plan for the prevention of child abuse and neglect by January 1, 1983. To implement prevention programs which are identified by the statewide plan, $2.2 million was set aside by the Legislature.

These prevention projects are now functional in each district and will provide a wide bounty of data for analysis and future directions in prevention of child abuse and neglect.

Florida is leading the way and setting the pace for statewide prevention, intervention, treatment, and educational efforts in the field of child abuse and neglect.

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APPENDIX B

CHILD ABUSE PREVENTION CONTRACTS
1983-84

DISTRICT	PLAN	CONTRACTOR
1	The District 1 task force identified the need for greater coordination between organizations who serve children and their families. The district is contracting for two coordinators, (one specializing in education) to provide training and to coordinate existing resources. The contract also provides for liaisons (one for each county in the district) to work with volunteer groups to help educate professionals and to begin implementation of programming identified by the task force as gaps in the prevention continuum. These programs include perinatal support, adolescent parenting and crisis care.	The West Florida Pediatric Foundation, Inc.
2	The District 2 task force identified the need for greater coordination between organizations who serve children and their families. Due to the large geographical area of the district (fourteen counties) five coordinators, 3 full time and 2 part time, were contracted to provide the following services: training for professionals in all communities on child abuse and neglect identification and reporting; assisting community organizations in the development of treatment and therapy programs such as teenage pregnancy programs, single parent support groups, parents anonymouse, etc.; the organization and implementation of parenting education groups in community colleges, health centers, and other local sources; emphasis placed on the development of volunteer supported services to families particularly in rural communities where funds for professionally staffed programs are severly limited; assisting in the implementation of the training to all school personnel in grades K-12.	O'Neal and Associates, Limited

DISTRICT	PLAN	CONTRACTOR
3	District 3 has contracted for 1 service director and 16 half-time county service coordinators. The service coordinators are responsible for coordinating public awareness, Education of Professionals, Curriculum for children aged 0-18, Parenting Education, Support Services, and Expanded Prevention Programs in the health services.	University of Florida Department of Pediatrics
4	1. Prenatal and Perinatal support services to high risk parents. This program will identify high risk families in hospitals and health clinics and provide a variety of educational and support services for these families, including referral to other prevention oriented services.	Children's Crisis Center, Inc. (District 4A) Childbirth and Parenting Education Association, Inc. (St. Johns) Children's Crisis Team of Volusia and Flagler Counties (Volusia)
	2. In-home preventive srevices (e.g., homemaker services) to high risk families referred by Prenatal and Perinatal Prevention projects and HRS.	Visiting Nurse Association
	3. Expansion of Parent Education Training to high risk families referred by Prenatal and Perinatal Prevention in-home services and HRS.	Child Guidance Clinic, Inc.
5	1. Community and Parent; Educational and Awareness campaign.	Family Services Center (Pinellas)
	2. Community and Parent; Educational and Awareness campaign.	Youth and Family Alternatives (Pasco)
	3. Parental Stress Hotline.	Alternative Human Services

DISTRICT	PLAN	CONTRACTOR
6	1. Sub-district 6A; Parent Education and and support services for Pregnant Adolescents and Incarcerated mothers of preschool children, which represent a large segment of the high risk population.	Hillsborough County Mental Health Center (Hillsborough and Manatee Counties)
	2. Sub-district 6B; Parent Resource Center. This center provides at at least eight services such as a Parent Stress Hotline and Parent Education. Information and referral services communication awareness projects.	Peace River Mental Health
7	The District 7 task force contracted for four coordinators. The specific tasks of these people is to identify available services for target populations, assess the need for additional services, identify and establish parent education programs for District 7, and to provide in-service training for professionals (e.g., teachers). Also the District 7 task force created a child abuse prevention fund. This fund is used to purchase materials directly related to child abuse prevention (e.g., public awareness materials). Also the coordinators for FY 1983-84 are recruting volunteers to work with high risk families, promoting and establishing parents anonymous groups, promoting parent education programs. The coordinators are also establishing puppet shows for young children on abuse and neglect.	Orange Regional Medical Center The Green House Family Counseling Center Osceola County Mental Health Services
	The District 7 task force has contracted for four primary prevention programs.	
	• Time Out for Mothers. This program is for poverty level mothers who do not qualify for day care but are in a high risk group. To get this full time out service (babysitting) the parent must agree to attend parent education classes and contribute toward providing time out for other mothers.	Time Out for Mothers
	• Parent Hotline. Telephone parent stress counseling service.	Parent Hotline

DISTRICT	PLAN	CONTRACTOR
7 (Cont.)	• Perinatal Program for First Time Teenage Mothers. This is a volunteer support and training program. The volunteer works with the mother during the last few months of pregnancy and 6-9 months after the child is born.	Perinatal Program for First Time Teenage Mothers
	• Parent Support Outreach. This outreach program is for any high risk parent. It is a volunteer support program for parents who need supportive services and parent education but who would not otherwise avail themselves of the services.	Parent Support Outreach
8	1. Sub-district 8A;	
	• Transportation services for DeSoto County residents.	Sarasota County Guidance Clinic
	• Parent Aide Program which involves volunteers providing intensive services.	Community Coalition
	• Parents Anonymous.	Community Coalition
	2. Sub-district 8B;	
	• Evaluation of child abuse and neglect project in sub-district 8-C.	Lee County Mental Health
	• Sex Abuse victim treatment program.	Child Protection Team
	• Treatment program for victims of child abuse and community awareness.	Dr. Joe White (Charlotte County)
	• Treatment program for victims of child abuse or neglect and community awareness.	David Lawrence Mental Health Inc. (Collier County)
	• Treatment program for victims of child abuse or neglect and community awareness.	Dr. Joe White (Hendry/Glades County)

DISTRICT	PLAN	CONTRACTOR
9	The District 9 task force contracted for an outreach program to serve high risk families. Services provided as part of this project include: 1. SCREENING AND IDENTIFICATION OF "HIGH-RISK FAMILIES through the development of an easily-administered check-list for use by professionals and para-professionals who come into contact with families and children (e.g., public health workers, day-care providers, nurses, social service agencies); 2. EARLY INTERVENTION WITH "HIGH-RISK FAMILIES" through (a) provision of counseling and referral services; (b) in-home parent-helper/parent-trainer services provided by trained family management specialists; and (c) "friendly visitor" services provided by trained volunteers to new parents during the critical period of mother-infant bonding after birth; 3. EDUCATION OF THE COMMUNITY-AT-LARGE AND EDUCATION OF PROFESSIONALS AND PARA-PROFESSIONALS in the dynamics and indicators of child abuse and neglect, high-risk factors, reporting procedures, and available resources for referral; 4. Making CRISIS COUNSELING available through a 24 hour-a-day telephone system and providing EMERGENCY AND RESPITE CARE for children through the use of emergency foster homes; 5. ESTABLISHING PARENT SUPPORT GROUPS AND OFFERING SUPPORT SERVICES (including lending cupboards of baby equipment, infant's and children's clothing, and household items); and, 6. PROVIDING PARENTING EDUCATION through (a) widespread distribution of brochures and pamphlets about parenting, child-development, and family-life; (b) in-home parent-helper/parent-trainer	Children's Home Society of Florida

DISTRICT	PLAN	CONTRACTOR
9 (Cont.)	services provided by trained family management specialists; (c) therapeutic "play-groups" for mothers and children; and (d) parenting classes.	
10	One prevention coordinator to integrate all services in Broward County. Community Education and Training.	Children's Consortium
	Therapeutic day care program.	Kids in Distress
11	1. During FY 82-83, one site of the Crisis Nursery was being funded through Children's Medical Services as a special project of the Child Protection Team. This funding was cut for FY 83-84, therefore both sites of the Crisis Nursery (one to service clients north of N.W. 36th Street, and one to service clients south of N.W. 36th Street) as well as the Crisis Hotline are funded through the Child Abuse and Neglect Prevention Allocation. This program provides respite care for children whose parents are under stress, and a hotline for use by children and parents who feel they are in danger.	Parent Resource Center
	2. Home Visitor/Parent Education/Child Advocate. This program offers periodic home visits, parent education to high risk families and an ombudsman to ensure all available services are offered to families.	JESCA
	3. Originally this contract was awarded to Community Mental Health Center of the Lower Keys. Due to some internal problems, this Agency was defunded by the Mental Health Board and was dissolved. During the period necessary to let an RFP, an OPS contract in the amount of $2,500 was entered into with the Child Abuse Specialist originally employed by Community Mental Health. The contract was awarded to Florida Keys Memorial Hospital in September, 1983. The Child	Monroe County

DISTRICT	PLAN	CONTRACTOR
11 (Cont.)	Abuse Specialist has continued to provide the needed services which include: • Working with existing agencies to establish and futher develop the Monroe County Coalition Against Child Abuse. • To identify and coordinate all the existing programs within Monroe County, all the various agencies throughout Monroe County and all the various personel and resources available to facilitate the provision of services in the prevention of child absue in Monroe County. • To develop a comprehensive guide of all programs to include current activities, policies and procedures and interface programs with other programs presently available in Monroe County. • To work with Monroe County Sheriff's Department, State Attorney's office, HRS staff, emergency room staff, day care staff and other appropriate agency staff in need of training in these areas of child abuse and neglect. • To work with the State Attorney's office with the appointment of a primary attorney to specialize in child abuse cases. • Work towards developing a guardian-ad-litem program similar to that being utilized throughout other counties and districts in the State, and attempt to secure community support.	

CSCSUB 296, Second Engrossed

A bill to be entitled An act relating to the prevention of child abuse and neglect; creating S. 027.075, Florida Statutes; providing legislative intent; requiring a state plan for a comprehensive approach to the prevention of child abuse and neglect; providing for state and local coordination; providing for district plans; providing that funding for child abuse and neglect prevention efforts be based upon the state plan; requiring biennial revisions of the state plan; providing for distribution of funds; providing an effective date

Whereas, in calendar year 1980 there were 71,522 children involved in reported cases of abuse and neglect representing a 192 percent increase of the reported number in fiscal year 1974-1975, and

Whereas, of all abuse and neglect cases disposed over the last 2½ calendar years only 10 to 23 percent were required either voluntarily or involuntarily to receive counselling or services and only 9 percent of the cases were judicially handled, and

Whereas, in 1979 the number of reported cases of sexual assault on children in Florida increased by 600 percent and national studies indicate that 1 in 10 females will be victims of sexual assault by relatives during childhood, and

Whereas, 70 percent or more of all sex offenders have themselves been the victims of a sexual assault or have experienced a sexual trauma during their childhood, and

Whereas, some studies on prison populations have indicated that as many as 80 to 90 percent of the inmates had been abused as children, and

Whereas, almost 65 percent of the dependent children admitted to state hospitals in 1978 had histories of abuse and neglect, and

Whereas, studies of dependency case files in Florida have indicated that 38 percent of those children who were abused or neglected have later known histories of status offense or delinquent behavior, and

Whereas, national studies have shown that child abuse is the reason 1,500 children a year develop cerebral palsy as a result of brain damage and that many children become mentally retarded, and

Whereas, the Legislature recognizes the costs associated with child abuse and neglect not only with regard to the victimized child and the child's family but also the hidden costs of child abuse in later generations, and

Whereas, the ever increasing number of children who are abused heightens the concern of the Legislature about the need to save lives of children who are abused and neglected, to avoid the physical and emotional suffering caused by the abuse and neglect, and the need to reevaluate the approach the state has heretofore taken with regard to this immensely complex and important family problem,

Now, therefore, be it enacted by the Legislature of the State of Florida:

Section 1. Section 827.075, Florida Statutes, is created to read:

827.075 Prevention of abuse and neglect of children.—

(1) Legislative Intent.—The incidence of known child abuse and neglect has increased rapidly over the past 5 years. The impact that abuse and neglect has on the victimized child, siblings, family structure, and inevitably on all citizens of the state has caused the Legislature to determine that the prevention of child abuse and neglect shall be a priority of this state. To further this end, it is the intent of the Legislature that a comprehensive approach for the prevention of child abuse and neglect be developed for the state and that this planned, comprehensive approach be used as a basis for funding.

(2) Plan for Comprehensive Approach.—

(a) The Department of Health and Rehabilitative Services shall develop a state plan on the prevention of child abuse and neglect and shall submit the plan to the Speaker of the House, the President of the Senate, and the Governor no later than January 1, 1983. The Department of Education shall participate and fully cooperate in the development of the state plan at both the state and local level. Furthermore, appropriate local agencies and organizations shall be provided an opportunity to participate in the development of the state plan at the local level. Appropriate local groups and organizations shall include, but not be limited to, community mental health center, quardian ad litem program for children under the circuit court, school board of the local school districts, district human rights advocacy committee, private or public organization or program with recognized expertise in working with children who are sexually abused, physically abused, emotionally abused, or neglected and with the families of such children, private or public program or organization with expertise in maternal and infant health care, multidisciplinary child protection team, child daycare center, law enforcement, and circuit court, if a guardian ad litem program is not available in the local area. The state plan to be provided to the

Legislature and the Governor shall include, as a minimum, the information required of the various groups in paragraph (b).

(b) The development of the comprehensive state plan shall be accomplished in the following manner:

1. The Department of Health and Rehabilitative Services shall establish an interprogram task force comprised of representatives from the Children, Youth and Families Program Office, the Children's Medical Services Program Office, the Alcohol, Drug Abuse and Mental Health Program Office, the Health Program Office, the Developmental Services Program Office, and the Office of Evaluation. Representatives of the Department of Law Enforcement and of the Department of Education shall serve as ex officio members of the interprogram task force. The interprogram task force shall be responsible for the following:

a. Developing a plan of action for better coordination and integration of the goals, activities, and funding pertaining to the prevention of child abuse and neglect conducted by the department in order to maximize staff and resources at the state level. The plan of action shall be included in the state plan.

b. Providing a basic format to be utilized by the districts in the preparation of local plans of action in order to provide for uniformity in the district plans and to provide for greater ease in compiling information for the state plan.

c. Providing the districts with technical assistance in the development of local plans of action, if requested.

d. Examining the local plans to determine if all the requirements of the local plans have been met and if they have not, the task force shall inform the districts of the deficiency and request the additional information needed.

e. Preparing the state plan for submission to the Legislature and the Governor. Such preparation shall include the collapsing of information obtained from the local plans, cooperative plans with the Department of Education, and the plan of action for coordination and integration of departmental activities into one comprehensive plan. The comprehensive plan shall include a section reflecting general conditions and needs, analysis of variations based on population or geographic areas, identified problems, and recommendations for change. In essence, the plan shall provide an analysis and summary of each element of the local plans to provide a statewide perspective. The plan shall also include each separate local plan of action.

f. Working with the specified state agency in fulfilling the requirements of subparagraphs 2., 3., 4., and 5.

2. The Department of Education and the Department of Health and Rehabilitative Services shall work together in developing ways to inform and instruct appropriate district school personnel in all school districts in the detection of child abuse and neglect and the proper action that should be taken in suspected cases of abuse and neglect. The plan for accomplishing this end shall be included in the state plan.

3. The Department of Law Enforcement and the Department of Health and Rehabilitative Services shall work together in developing ways to inform and instruct appropriate local law enforcement personnel in the detection of child abuse and neglect and the proper action that should be taken in suspected cases of abuse and neglect.

4. Within existing appropriations, the Department of Health and Rehabilitative Services shall work with other appropriate public and private agencies to emphasize efforts to educate the general public about the problem of and ways to detect child abuse and neglect and the proper action that should be taken in suspected cases of abuse and neglect. The plan for accomplishing this end shall be included in the state plan.

5. The Department of Education and the Department of Health and Rehabilitative Services shall work together on the enhancement or adaptation of curriculum materials to assist instructional personnel in providing instruction through a multidisciplinary approach on child abuse and neglect identification, intervention, and prevention. The curriculum materials shall be geared toward a sequential program of instruction at the four progressional levels K-3, 4-6, 7-9, and 10-12. Strategies for encouraging all school districts to utilize the curriculum are to be included in the comprehensive state plan on child abuse and neglect prevention.

6. Each district of the Department of Health and Rehabilitative Services shall develop a plan for its specific geographic area. The plan developed at the district level shall be submitted to the interprogram task force for utilization in preparing the state plan. The district local plan of action shall be prepared with the involvement and assistance of the local agencies and organizations listed in paragraph (a) as well as representatives from those departmental district offices participating in child abuse and neglect treatment and prevention. In order to accomplish this the district administrator in each district shall establish a task force on the prevention of child

abuse and neglect. The district administrator shall appoint the members of the task force in accordance with the membership requirements of this act. In addition, the district administrator shall ensure that each subdistrict is represented on the task force and if the district does not have subdistricts the district administrator shall ensure that both urban and rural areas are represented on the task force. The task force shall develop a written statement clearly identifying its operating procedures, purpose, overall responsibilities, and method of meeting responsibilities. The district plan of action to be prepared by the task force shall include, but not be limited to:

a. Documentation of the magnitude of the problem of child abuse, including sexual abuse, physical abuse, and emotional abuse, and neglect in its geographical area.

b. A description of programs currently serving abused and neglected children and their families and child abuse and neglect prevention programs, including information on impact of programs, cost effectiveness, and sources of funding.

c. A continuum of programs and services necessary for a comprehensive approach to all types of child abuse and neglect prevention as well as a brief description of such programs and services.

d. A description, documentation, and priority ranking of local needs related to child abuse and neglect prevention based upon the continuum.

e. A plan for steps to be taken in meeting identified needs, including the coordination and integration of services to avoid unnecessary duplication and cost, and alternative funding strategies for meeting needs through the reallocation of existing resources, utilization of volunteers, contracting with local universities for services, and local government or private agency funding.

f. A description of barriers to accomplishment of a comprehensive approach to child abuse and neglect prevention.

g. Recommendations for changes that can be accomplished only at the state program level or by legislative action. The district local plan of action shall be submitted to the interprogram task force by November 1, 1982.

(3) FUNDING AND SUBSEQUENT PLANS.—

(a) All budget requests submitted by the Department of Health and Rehabilitative Services, the Department of Education, or any other agency to the Legislature for funding of child abuse and neglect prevention efforts shall be based on the state plan developed pursuant to this section.

(b) At least biennially, the Department of Health and Rehabilitative Services at the state and district levels and other agencies listed in subsection (2)(a) shall readdress the plan and make necessary revisions. Such revisions shall be submitted to the Speaker of the House of Representatives and the President of the Senate no later than January 1, 1985, and by January 1 of alternate years thereafter.

Section 2. (1) Any appropriation provided for the implementation of this act shall be distributed to each district based on the percentage of the total state reported cases of child abuse and neglect reported in the district and the percentage of the total state populationat risk of abuse and neglect in the district with equal weight being given to each factor. The distribution of the funds to each district shall be contingent upon the completion of the plan of action for the prevention of child abuse and neglect for the district as required in section 1 of this act and the acceptance of the plan as being complete by the interprogram task force. If a district fails to provide a local plan of action that includes all of the required elements by November 1, 1982, all funds identified for use by that district shall be redistributed by the Department of Health and Rehabilitative Services to one or more districts based upon additional proposals submitted for utilization of the forfeited funds for prevention programs for child abuse and neglect. The interprogram task force shall select the proposals to be funded.

(2) By utilizing the information contained in the district local plan of action and the priorities established in the plan, the district shall develop a request for proposals to obtain proposals for meeting identified priority needs. Such proposals shall be ranked by the group that participated in the development of the district plan. The priority ranking shall be made according to the extent the proposals meet identified needs criteria for cost effectiveness, provision for an evaluation component that will provide outcome data, provision for a parenting education component, and a determination that the proposal provides a mechanism for coordinating and integrating services with other services that are considered necessary for working with the target population. Once the proposals have been analyzed and ranked in order of preference, the list shall be submitted to the interprogram task force. After each district's proposals have been determined to be complete, each district will be notified and the funding released to the district.

Section 3. This act shall take effect upon becoming a law, except that section 2 shall take effect July 1, 1982.

Mr. ANTHONY. Thank you very much, Dr. Whitworth.

Mr. Bliley, I think I will let you begin inasmuch as one of the panel members happens to come from your State; even from your city.

Hopefully the chairman will be back. He is proud to have you here, Dr. Whitworth, showing what the State of Florida has done.

Mr. Bliley?

Mr. BLILEY. I have some questions I am going to give to you, and you can respond in writing. But in light of the time I will only ask a couple.

Dr. Fontana, I was very impressed with your testimony. Could you tell me what the cost of the safety program is in the city of New York?

Dr. FONTANA. The cost is about $200,000. We talk about the one child being admitted for a night or 2 nights. It is probably $80 a night, or less than $80 a night for a child being rescued from a child situation.

Mr. BLILEY. Thank you very much. I will have some other questions for you. But we have a time problem.

Ms. Schuchert, it is nice you could join us today. One question. In your testimony you said that programs developed by Parents Anonymous are based on what families say they need, not what others say they need. Could you please elaborate on that, and perhaps give some examples of both kinds of programs?

Ms. SCHUCHERT. I think all of us in the field who have been studying families for a number of years have learned a great deal from them. If we take time to listen to what they say their needs are, and develop sensitive programs to respond to those needs, we find that the services offered are more effective. So I think all of us have learned from the people we serve in terms of——

Mr. BLILEY. Can you give us some examples?

Mr. SCHUCHERT. Parents Anonymous is one example. The program developed for the corrections system in Virginia is another. I think we have learned that volunteers are a great resource because families need to have a model for parenting. We are treating parents who were not parented in their own growing up years, so we are finding that one has to go back and have that feeling of having one's needs met in order to provide for the needs of the children. So we have learned that the use of volunteers is very helpful as well from the parents we serve.

Mr. BLILEY. Thank you very much. Thank you, Mr. Chairman.

Mr. ANTHONY. Thank you, Mr. Bliley.

I would like to thank all of the members of the panel. I think your testimony has contributed greatly to our record. Each of you have independently, though, hit on a couple areas that I am personally concerned about, even before I came to the meeting.

Two of you have highlighted problems that may be as a result of something that Congress was doing in a different area; that is, the medicare area. I would like to touch on that first.

Dr. Green, you said you supported what Dr. Fontana said about the fact that the Congress was trying to save the medicare system when we put in prospective payment. We now have a medicare cost containment program with DRG's. Do you have any suggestions to make to this committee that we might pass on to the committees of jurisdiction about this particular problem? Is your association following up with the proper officials of the committees of proper jurisdiction to see that legislation will not hinder your efforts?

Dr. Fontana, first.

Dr. FONTANA. I think it is a real problem that has to be worked on by the legislators and people having to do with hospitals' administration and fiscal matters, because right now we cannot admit a child for social reasons. It has to have a medical problem. If we can find some kind of medicaid reimbursement to pay for that child's 1 night or 2 nights until the social problems or family problems are dealt with, and that child is either placed back with the parents or placed in the social program with foster care or whatever, the point to be made is that there are a lot of empty pediatric beds today in hospitals that are not being filled that could be filled so that a crisis nursery could be in every hospital.

The only stumbling block is the process of payment. Hospitals will not accept a child unless they get paid for it. There is no way, no diagnosis we know of that we can put on a child that comes in unless the child has been abused. Once a child is abused and battered there is no problem about admitting the child. But if the child is on the verge of being battered or abused or even killed and the mother wants to drop the child off as a rescue operation, there is no way of that child being admitted.

Mr. ANTHONY. You say this really is an unintended consequence of trying to solve the escalation in health care costs. But you consider it to be a major problem in dealing with the child abuse problems?

Dr. FONTANA. I think it is a major problem in view of the escalation of child abuse. We are thinking about 80 percent of our families today that are going to be troubled, not enough to bring a family to a hospital setting but in our 2 years the number of children we have seen, we have had over 4,000 parent help calls——

Mr. ANTHONY. You gave a staggering figure. You said a 15 percent growth factor in child abuse. Why? With all the programs we have ongoing across the United States why is there a 15 percent——

Dr. FONTANA. Even more so, why are two children dying every week in New York City? And I am sure the same is going on throughout the country. The fact is that we have had an epidemic of teenage pregnancies; 600,000 keep their babies and there are babies raising babies without any parenting. Parenting is not something you are born with. It is something that is modeled. They haven't had this parenting input.

Second is the divorce and separation, that epidemic in this country, in addition to the fact we are having increase in alcoholism and drug addiction.

Last but not least, the economy where parents have to go out to work or parents are not working and taking their frustrations out on their kid. We are talking about verbal or physical abuse. You don't necessarily have to break a kid's arm by abusing a child, you can break his spirit—"you're dumb, you're a whore, get out of my way."

What the Government is doing at the present time, instead of increasing funding for children and the family support system it is decreasing. As I mentioned, we are concerned about a handicapped child, Baby Jane Doe. That is fine; we should be concerned about handicapped children. But what about the 4,000 children that die in the country that are normal children? Yet, the funds are being cut. Sixteen million dollars are being provided, which means if there are a million kids being abused that is $16 per child. It is ridiculous.

Mr. ANTHONY. I don't know if you saw "60 Minutes" last night.

Dr. FONTANA. Yes, I did.

Mr. ANTHONY. The parents of Baby Doe made the same point you are making from your position of expertise. I take it your program is funded by New York City?

Dr. FONTANA. Yes.

Mr. ANTHONY. Your program is funded by the District of Columbia, or in-house?

Dr. GREEN. Medicaid program, a variety of small grants. No Federal funds at the present time.

Mr. ANTHONY. Dr. Whitworth, yours is strictly a State program?

Dr. WHITWORTH. About 90 percent State, 10 percent Federal.

Mr. ANTHONY. The one you are with, Ms. Schuchert, is Parents Anonymous, which does get some Federal funding?

Ms. SCHUCHERT. Through our national office; Federal funds are paying seed moneys for our children's programs right now. That is all. The rest of us have independent funding.

Mr. ANTHONY. That brings me back to the most sensitive part of the issue. What is the proper role for the Federal Government? I think that is what we are trying to determine today so we can establish some type of record as to whether or not $16.2 million in one small preventive and treating child abuse program is sufficient, or if we need to expand the program with dollars, or expand it into what you referred to as networking.

Dr. FONTANA. Mr. Anthony, this——

Mr. ANTHONY. What do you see as the Federal Government's role?

Mr. FONTANA. It has to be to recognize the fact that we are abusing and neglecting our children. We are not providing them with the necessary support systems. We are spending more money on fragmenting families than on keeping families together. I think the Government has to recognize first that children are this nation's most important natural resource. There is the future our society, if we are allowing them to go out on city streets and be kicked out and throwaways and runaways.

The point I am trying to make is that I don't believe, well, 20 years ago when I spoke to Senator Humphrey about child abuse and we tried to get the Senate together with Dr. Kempe and Dr. Helfer, the remarks made by some people in legislation was "I read about child abuse in one of the magazines." In other words, I don't believe the community as well as the people that are running our country recognizes the fact that child abuse is one of the most important medical social problems we have to be confronted with. It feeds into the crime and violence we are seeing in our country, and feeds into the juvenile delinquency rate. All these things. It is not a matter of just one child being abused and a parent abusing a child. It is a fact that it is destruction of our family unit, deterioration of our society.

Mr. **Anthony**. Let me interrupt you there. Let us say that is a given, we all agree with that. But in the Congress we have different viewpoints as to how you solve a problem. Some say you just can't throw money at the problem and solve it. Some say that you can put more money into these programs and solve the problem. I am trying to ask you what the Federal Government's role is in this problem. You have all stated in your testimony that funding is a problem. You have approached it from different directions because you are involved in it from different directions. But I am in the Federal Government. That is really about the only part that I can play right now other than making recommendations to the Governor of the State of Arkansas or to our local community, trying to establish some of the programs that you have going.

But for instance, should the National Institutes of Health be involved in this? Can we do more through vocational education and maternal and child health programs? I am asking if there are other programs available to network with? Can we network what we have already going in the Federal Government to tie the programs together in a more comprehensive, cohesive action? I agree with you and am well aware of the problem. I spent 10 years of my life before coming to Congress dealing with child abuse of all kinds from the judicial standpoint as a deputy and as an elected prosecuting attorney for a five county area. It is a terrible problem and a problem not many people really understand. When I would go back and tell my friends and members of my family some of the things going on in their community, they had a hard time even acknowledging or believing me until something happened with one of their close friends. Invariably they would come and say, "Hey, let me tell you what I just found out about." So just making people aware, No. 1, I think is a very severe problem.

Dr. **Green**. More than that. Prior to 1973, when there was no National Center on Child Abuse and Neglect, there were only three or four States in the country that had reasonable programs addressing child abuse and neglect. In the 10 years since the National Center has been in existence there has been considerable improvement in the identification, in the management, in the follow up of children across the country.

The Federal Government should act as a catalyst to make certain that programs develop not only at the Federal level but also to stimulate States to develop their own programs, and to support and monitor and evaluate those programs.

Dr. **Fontana**. The National Center at the first 5, 6 years started developing innovative programs. We now know those innovative programs which have been found effective, multidisciplinary approach is effective in 80 percent of the most deprived individual, so we can turn him around and keep him together. We know that. As far as I am concerned, being involved with the National Center, a great deal of that money went right down the tubes. We shouldn't allow that to happen to Government money. I think what we can do is be able to take that money and put it into programs, replication of programs we have found to be effective throughout the country. We have to have a National Center. But that National Center also as we first proposed which it never carried out is to have a committee of people who can have some input in policymaking and directive so that grants that are approved are not being approved by simply the bureaucracy who has been in there 30 years and is not really concerned about what is happening out on the front line, but to have people involved in programs to make joint decisions as what programs should be funded and what should not, which is not going on at this point.

Mr. ANTHONY. Ms. Schuchert.

Ms. SCHUCHERT. Dovetailing your statement, Dr. Fontana, is the fact that the National Center now has an even more important role in keeping us all together and helping us know what everyone else is doing. Your dismantling Regional Resource Centers on Children, Youth and Families at the end of the year. They have helped us network and it helped coordinate programs for children, youth and families on the regional level. Without those centers I see the National Center as being a conduit for information, national voice for child abuse and neglect. It is one that needs to be heard if we are going to educate our communities.

Another issue is the moneys you send to States. The moneys that you give to health and mental regardation, social services, corrections, is pretty categorical. Prevention priorities tend to be at the low end of the priority totem pole, if you will. If you can think of some ways to encourage States to reprioritize prevention in a higher strata so that all of the agencies who work with families will look at prevention as more appropriate and cost effective than warehousing or providing services, hopefully this will help us treat families better because the focus has to be prevention.

Mr. ANTHONY. Dr. Whitworth, we will let you be the cleanup batter.

Dr. WHITWORTH. To further amplify that comment, as you look around at various States you will find some are doing a very good job as far as spending dollars on prevention, and also child abuse in general. One concept that may well be effective for those States that are not doing that, who are not addressing the issue, is the potential for matching funds, for the individual States to have to come up with dollars to be able to tap Federal dollars to get support for the programs they want to get started.

Clearly, I would not like States that have done a good job to not be able to get continuation of funds. But at the same time, looking at it from a national perspective I would like to see some effort made on the national level to encourage States to get involved. One way to do that is to provide dollars with a hook.

Ms. SCHUCHERT. 96-272 is a beginning. OK. Are you familiar with providing treatment services to children before they leave their homes? That is a good beginning. Let us expand on that.

Mr. ANTHONY. I would like to thank the panelists, and the other people who have testified, on behalf of the chairman and other members of our task force. I think that this is just a small beginning in trying to establish a good public record so that we can make some decisions as to how to correct, what I must agree with you, from personal experience, is a terrible problem. We haven't resolved it over the years or with all the effort we have put into it.

We should establish it as one of our national priorities. We will try to find the proper answers and submit suggestions to the proper committees of jurisdiction.

I would like to close on this note. I happen to serve on another committee that has jurisdiction over the medicare issue. I was right in the middle of trying to establish prospective payment. I know we have a report due to the Congress on how it is working. I would love to work with you two gentlemen, and look at possible corrections and solutions to what I know is an unintended, problem. I would also like to take a look to see if there may be a way to help solve the problem by using another piece of legislation.

The task force hearing is now adjourned subject to the call of the Chair.

[Whereupon, at 1 p.m., the task force was adjourned, to reconvene subject to the call of the Chair.]

[Material submitted for inclusion in the record follows:]

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May 23, 1984

The Honorable George Miller
U.S. House of Representatives
Select Committee on Children, Youth
and Families
Room H2-385 House Office Building Annex 2
Washington, DC 20515

Dear Congressman Miller:

Enclosed please find:

- My testimony before your Committee on March 12th, with corrections
- Answers to the additional questions posed by Congressman Lehman

It was a pleasure to testify before your Committee. I hope that you will seriously consider my comments on the children's trust funds, particularly as they appear at the end of the attached questions and answers. We at the National Committee for Prevention of Child Abuse are ready to help you in any additional ways you would like. Thank you.

Sincerely,

Anne H. Cohn
Executive Director

AHC/kch

Responses to Additional Questions from the Honorable William Lehman
by Anne H. Cohn

1.Q. What do we know specifically about the causes and precipitating events leading to child abuse? What can we do to prevent child abuse and neglect by addressing some of the underlying causes?

A. In my paper "An Approach to Preventing Child Abuse" (attached) the answer to this question is discussed in detail and includes numerous references to the salient literature. See particularly pp.3-18.

2.Q. How might we address the complicated issues of both prevention and treatment in areas where promising mechanisms are not in place or likely to be in place for quite a while?

A. We have found two critical ingredients in solving this problem. First, there is a need for a citizen-based, volunteer-based committee which pulls together all of the different segments of a community or state--professional, business, government, civic--so that collectively this group can identify the greatest needs and begin to respond to them. The NCPCA chapter, of which we now have 46, is the model of what I am talking about. Second, there is a need for a state-level Children's Trust Fund which can provide small grants to communities for the development of media services. Having said this, I do believe that the primary responsibility for treatment is different than prevention.

I believe that putting quality treatment services in place where they do not already exist is ultimately the responsibility of government; yet given scarce resources, there are many promising approaches which government can encourage which are not costly and have been shown to be effective. I refer specifically to Parents Anonymous-type groups and parent aide programs. If a state had a Children's Trust Fund, seed monies from these could be used to encourage the development of such programs and a state citizen committee could help in identifying needs. On the other hand, communities, neighborhoods, local citizens can, I believe, play the significant role in the prevention area, working through hospitals,schools, community centers and neighborhood groups and develop needed prevention programs such as prevention education.

3.Q. We often see that abuse is multi-generational in character. What do we know about that? And, what kind of efforts have been successful in breaking the cycle of abuse?

A. Study after study shows us that abusive parents had seriously problematic childhoods, usually characterized by abuse or neglect. Regardless of the form of abuse or neglect, it is clear that the way one is parented has a lot to do with the way one parents. Thus, while some studies have failed to prove that there is a one-to-one correlation between physical abuse, the evidence is that child abuse is multi-generational.

Our data base on "breaking the cycle" is weak, but suggests the following avenues as promising:

* therapy for the abused child to help the child overcome the emotional

and developmental problems which result from abuse

- * self-help groups for abused children, (such as the Parents Anonymous Children's groups) to overcome the scars of abuse, particularly the feelings of isolation and low self esteem
- * self help groups for young adults who were abused as children to help them come to terms with the problems they may have as parents
- * parenting and support programs for new parents to help them develop more positive approaches to parenting than they otherwise would have.

4.Q. There is rapidly growing public awareness about the problems and consequences of physical and sexual abuse, in part because of broad educational efforts and the results of increased reporting. What do we know about the problems and prevention of emotional abuse of children that is usually less visible but just as insidious as other types of abuse?

A. We know a fair amount (although certainly not as much as there is to know) about emotional maltreatment of children. I recommend to you the Garbarino's paper entitled "Emotional Maltreatment of Children", published by the National Committee for Prevention of Child Abuse. (attached).

What we know very little about is the prevention of emotional abuse, largely because so little work has been done in this area. Of the very few promising efforts is a film done by the Junior League and others in Illinois called "Ask Peter" which sensitizes parents to the harsh impact of verbal abuse. Because the dynamics of emotional and physical abuse are quite similar, it is reasonable to assume that many of the physical abuse prevention strategies would be effective emotional maltreatment prevention strategies. This is conjecture at this point, however, because of the paucity of work in this area.

5.Q. We know that the consequences of child abuse and neglect are costly in every sense. What do we know about the cost of treating a child who has been abused and his family? How much does it cost to provide preventive services?

A. As measurable and as compelling as treatment and prevention cost figures are, the truth is that we have been using rather shabby figures for quite a while. There is a great need for a well done study on the cost and cost effectiveness of alternative treatment and prevention strategies.

I use figures from the first National Evaluation Study of Child Abuse and Neglect Demonstration project, a study which I directed and which was completed 6 years ago. That was the first and to my knowledge only study to date which has looked at issues of cost effectiveness. The study was limited to treatment approaches. It showed that the average costs for 6 months of investigation treatment for a family reported for abuse or neglect was $ 1865. The cost of therapeutically treating an abused child for one year was on average $ 7409 . These figures do not include legal/judicial or medical costs. So, even 6 years ago, total treatment costs were higher than these figures.

The cost of preventive services obviously varies dramatically, depending upon the type of preventive service you are talking about. A self-help group for formerly abused children may have almost no costs associated with it. A home health visitors program, in which a trained visitor visits a family regularly during the first year after birth and provides a variety of ancilliary services could cost $2000 or so per family. Firm figures are not available at this time and are desparately needed.

6.Q. We have heard a great deal about the importance of prenatal care in ensuring healthy child and family development. You note its role in helping to prevent problems of child abuse. What are some of the major concerns in this area and what are the implications for federal and local public policies regarding prenatal care and parent education?

A. Prenatal care is quite important in child abuse prevention from at least 2 points of view. First, low birth weight and sickly babies are at greater risk for abuse. Poor medical and nutritional care during the prenatal period can result in such infant conditions. Second, new parents without an understanding of child care or child development are at greater risk to abuse their children. Lack of parenting education during the prenatal period can result in such a prenatal condition.

The importance of comprehensive prenatal care, which includes parenting education and child development as a critical component, is clear. How we guarantee such quality care to all new parents is a tough question. One avenue is to assure that any federal (or state) funds used for prenatal care carry requirements about what such care should include. A second is to better educate the medical community about the importance of such comprehensive prenatal care. A third is to educate prospective parents about their need for such care. If we can then create a public demand for such care and a professional capacity to respond, we will certainly be closer to our goal than we are now.

In closing, let me reiterate my sense of the importance of the Children's Trust Fund. The trust fund is a very special way to assure that desperately needed dollars are generated for community-based prevention activities--the kinds of activities I have talked about in all of my answers above. I believe that there is a very clear role for the federal government to play with respect to these trust funds. A piece of legislature which enabled the federal government to provide matching funds to states which create such trust funds would be an invaluable incentive. The level of such matching funds could be capped (a) by the number of children in a state, eg. 50¢ per child under 12 and (b) by time, eg. for the first five years after the fund is enacted. States with trust funds already in place could also be rewarded with 5 years of matching funds. To assure appropriate controls, trust funds dollars, both state generated and the federal match, would have to be used exclusively for community-based prevention activities, as determined by a statewide citizens committee. With such parameters, federal appropriation would not exceed about $20 million annually or $100 million in total.

Thank you.

encl:"An Approach to Preventing Child Abuse"
"Emotional Maltreatment of Children"

children's hospital
national medical center 111 MICHIGAN AVENUE, N.W., WASHINGTON, D.C. 20010

DEPARTMENT OF CHILD HEALTH AND DEVELOPMENT, GEORGE WASHINGTON UNIVERSITY
CHILD HEALTH CENTER • RESEARCH FOUNDATION OF CHILDREN'S HOSPITAL

May 11, 1984

Congressman George Miller
Chairman
Select Committee on Children,
  Youth, and Families
U.S. House of Representatives
Room H2-385
House Office Building, Annex 2
Washington, D.C. 20515

Dear Congressman Miller:

Thank you for your letter of May 1. It was my pleasure to participate in the Select Committee's hearing on "Child Abuse: What We Know About Prevention Strategies." As you requested, I am enclosing the corrected transcript of my remarks.

I would offer the following response to Congressman William Lehman's question: "What can we do to help treatment and prevention systems mesh better to address both the presenting and underlying causes of abuse more effectively?"

> First, it is important to bear in mind that, in the country as a whole, resources for both treatment and prevention of child abuse and neglect are severely limited. This makes it extremely difficult to develop and maintain strong and consistent collaborative efforts among the many agencies and professions needed to address the problem effectively. More resources are needed.
>
> Further, all too often existing resources, especially at the community level, are so fragmented and dyscommunicative that effective coordinated efforts are difficult. A means should be found to enhance and encourage collaborative efforts.
>
> Secondly, the federal government should develop incentives to foster more community initiatives in the area of child abuse and neglect -- more outreach, more education, and more networking among all concerned. Too often, unfortunately, the reverse is the case. The most recent example is the Final Revision of OMB Circular A-122 "Cost Principles for Nonprofit Organizations." If these rules become effective, I believe they can only have a chilling effect on the ability of community groups to protect vulnerable children.

Please let me know if I can provide any further information. Thank you again for the opportunity to take part in the deliberations of the Select Committee.

Sincerely,

Frederick C. Green

Frederick C. Green, M.D.
Associate Director

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May 1, 1984

Leonard L. Lieber, LCSW
Executive Director
Parents Anonymous
22330 Hawthorne Boulevard, Suite 208
Torrance, California 90505

Dear Mr. Lieber:

This is to express my personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Child Abuse: What We Know About Prevention Strategies," held in Washington on March 12. I regret my schedule did not permit me to be there, but I know from reading the transcript that your participation contributed greatly toward making the hearing a success.

The Select Committee is now in the process of editing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to assure that it is accurate, and return it to us with any necessary corrections.

In addition, Representatives William Lehman and Thomas J. Bliley, Jr. have requested that the following questions be answered for the record:

Congressman Lehman

> I am pleased to learn of the return that the federal investment in self-help programs has helped to leverage. This and our other testimony suggest that we know quite a bit about how to confront and prevent the problems of child abuse even more deliberately and in a more coordinated way. How have Parents Anonymous programs typically dealt with issues of coordination of services in their local communities?

Congressman Bliley

1. How much is Parents Anonymous doing in the area of primary prevention; that is, prevention of child abuse before a first incident?

2. How are the federal dollars which go to the Parents Anonymous national organization used?

3. Why will Parents Anonymous be losing its federal support at the end of this year? What effect will the loss of federal support have on local chapters of Parents Anonymous?

4. I am very impressed with your idea of developing a national policy of self-help in this country. Do you find resistance to the idea of building self-help programs within child-serving agency settings?

Let me again express my thanks, and that of the other members of the committee, for your testimony.

Sincerely,

George Miller

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

GM/j

Enclosures

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May 8, 1984

Congressman George Miller
Chairman, Select Committee on Children, Youth
and Families
Room H2-385 House Office Building - Annex 2
Washington, D.C. 20515

Dear Congressman Miller,

We are responding to your request to review and correct testimony which was given at committee hearings in Washington on March 12, 1984.

I have taken the liberty of going through all of the material and have made a number of corrections, all of which are marked in red, as requested.

Additionally, the following are responses to other questions posed by Congressmen Lehman and Bliley:

Responding to Congressman Lehman's question:
On the local level, Parents Anonymous organizations use networking between the private and public sectors to deal with coordination of services.

Most PA programs are staffed by volunteers who are often key community leaders and key professionals in child abuse and neglect service agencies. Their roles are to help establish PA adult and children's programs and make their cost free availability known to both the lay and service communities.

One of our concerns is to lower the cost of human services and avoid duplication. By involving many different service levels in PA operations, this issue is better addressed.

Responses to Congressman Bliley's questions:
(1) Parents Anonymous' role in primary prevention has been extensive for many years and has increased with our advent of children's treatment programs.

Initially, our national and state 800 phone services receive thousands of calls annually from young parents who are worried about their potential for abuse and neglect. Their needs are addressed via phone and referrals are made to local support and counseling services to prevent their fears from becoming realized.

Since 1982, we have been developing a nationwide network of programs for abused children. Members are of ages from infancy through age 18 years. Parenting education programs for teen parents, as well as pregnant teens, treatment programs for younger children, etc. are all primary prevention programs designed to break the cycle of child abuse.

Furthermore, parenting education is commonly found as a resource for adult members of PA programs. This is a built-in plan to stop child abuse from re-occurring in younger families who may yet have more children.

(2) Federal dollars to the PA national organization are used for several major areas.

The single largest category is to provide small seed support grants of about $4,000 each to the approximately 30 children's treatment program sites. They are engaged in primarily volunteer operated, locally autonomous intervention and primary prevention programs. The PA national office administers and coordinates the program from whence valuable data is obtained which is used by community members and professionals both in this country and beyond.

The PA national office staff also serves in a similar coordinating capacity for our state offices/organizations serving over 40 states. We also serve many community groups not necessarily a part of larger organizations.

The PA national office operates the nation's most well-known toll free resource line for parents at risk of child abuse, referring them to local PA and other help resources.

Printed materials have been a major product of the PA national office for many years. Current funding helps to support Frontiers, the nation's most widely read publication containing a variety of timely and practical articles on child abuse prevention and treatment, written by persons engaged in the field throughout the country.

PA national staff are also involved in public education efforts, including National Child Abuse Prevention Month and national media activities via newspaper and electronic media.

We are also responsible for helping to expand services for American military families (here and abroad) who face special life stresses putting them at risk of child abuse. Coordinating PA services in this category is more a responsibility of a national office than state offices, though there is a PA coordinating unit in Germany for military families stationed in that part of the world.

Other federal dollars are used for salaries of 4½ staff persons here, office rent, supplies, etc.

(3) The Parents Anonymous national organization is faced with losing federal support on February 28, 1985. This is because of HR 1904's lack of specific language authorizing assistance to other than statewide self-help programs in the field of child abuse.

Plans within the National Center on Child Abuse and Neglect also precluded support, as funds had been earmarked for demonstration and research activities, and the like.

Loss of federal support to the PA national organization would have a deep and lasting effect on state and local PA organizations. Inasmuch as the PA national office serves as a national clearinghouse and coordinating body for the national PA network, the linkage in the interstate PA network would be virtually removed.

Many local chapters now (and in the future) dependent on the national office would have no effective leadership. Our military colleagues would be without direct assistance, as well.

The growth and development of the new children's programs would be stalled and the national parent referral system would be interrupted.

In short, what progress we have made thus far would be greatly halted and further economies which PA's cost-effective program generates would be brought to a stand-still.

(4) When we began 15 years ago, there was tremendous resistance, mostly in professional circles, to the use of self-help and volunteerism in the child abuse field.

Since then, as PA has been evaluated and as our program has grown and involved thousands of community volunteers and professionals, the credibility and value of our approach has grown.

More and more state level social service executives, national and community leaders, religious organizations, corporations, legislative bodies et al have backed PA efforts with public and private funds, personal endorsements, donated time, goods and services.

There are still pockets of resistance to self-help, mainly among those persons who have been trained in service fields which are based upon high fee-for-service standards.

However, the PA program and other self-help efforts are growing, flourishing and constantly proving their merit, justifying a permanent place in our social structure.

We trust that the responses to the questions posed by Congressmen Lehman and Bliley are sufficient, as is the edited and corrected material from the hearings. Thank you for your support of and interest in our efforts.

Sincerely,

Leonard Lieber

Leonard L. Lieber LCSW
Executive Director

LLL:al
Enc.

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May 1, 1984

Dr. J. M. Whitworth
655 West 8th Street
Jacksonville, Florida 32209

Dear Dr. Whitworth:

This is to express my personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Child Abuse: What We Know About Prevention Strategies," held in Washington on March 12. I regret my schedule did not permit me to be there, but I know from reading the transcript that your participation contributed greatly toward making the hearing a success.

The Select Committee is now in the process of editing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to assure that it is accurate, and return it to us with any necessary corrections.

In addition, Congressman William Lehman has requested that the following questions be answered for the hearing record:

1. What are the major problems that the State has encountered in implementing the statewide child abuse prevention effort? How have these issues been addressed?

2. How even is the distribution and utilization of prevention and treatment services across the State?

3. In what ways are local advocacy and private service groups integrated into the statewide programs at the State and district levels? What gaps remain?

Let me again express my thanks, and that of the other members of the committee, for your testimony.

Sincerely,

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

GM/j

Enclosures

COLLEGE OF MEDICINE • UNIVERSITY OF FLORIDA • GAINESVILLE 32610
DEPARTMENT OF PEDIATRICS

May 8, 1984

Honorable George Miller
Chairman
Select Committee on Children,
Youth, and Families
Room H2-385 House Office
Building Annex 2
Washington, D.C. 20515

Dear Representative Miller:

In response to your letter of May 1, 1984, I have revised my testimony only slightly and am returning it for inclusion in the record.

In response to the requests from Representative Lehman, the following statement has also been prepared for inclusion in the record:

The statewide prevention effort is organized through a State Task Force on the Prevention of Child Abuse and Neglect, and each of the eleven HRS districts in the State has a separate task force. Implementation has been a problem in those districts which found difficulty in organizing priorities or in which difficulty was encountered in finding provider groups and agencies which could provide high quality prevention services because of their orientation and training. Cross consultation between districts has largely solved this problem, but the effect of quarterly to yearly review of program effectiveness should serve to largely eliminate the problem in the future.

Prevention and treatment efforts are underway statewide, but evenness of distribution is a problem. Urban areas are very effectively served, and rural areas are well served in some areas and marginally served in other areas. Several plans to better serve all rural areas in general are now under study, and the need for satellite treatment teams is well recognized, but not yet funded.

There is a state and district mandate to involve private and advocacy groups in the functions of local and state task forces. The constituency for children is currently being developed on a statewide basis, as well as a state chapter of the National Committee for Prevention of Child Abuse. These agencies will be integrated at both decision-making levels in allocation of funds and program review. Great care has been taken to select a cross-section of the community in this process. However, gaps do remain in some districts, especially revolving around the need for mental health centers to be more responsive to the needs of abusive families, especially in the area of sexual abuse.

I hope these comments will be helpful to you. If I can be of any further assistance in the future, I will be happy to do so.

Sincerely,

J. M. Whitworth, M.D.
Associate Professor of Pediatrics
Child Abuse and Neglect

pdc

Enclosures

Please reply to:

J. M. Whitworth, M.D.
655 West 8th Street
Jacksonville, FL 32209

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May 1, 1984

Vincent J. Fontana, M.D.
The New York Foundling Hospital
1175 Third Avenue
New York, New York 10021

Dear Dr. Fontana:

This is to express my personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Child Abuse: What We Know About Prevention Strategies," held in Washington on March 12. I regret my schedule did not permit me to be there, but I know from reading the transcript that your participation contributed greatly toward making the hearing a success.

The Select Committee is now in the process of editing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to assure that it is accurate, and return it to us with any necessary corrections.

In addition, Representatives William Lehman and Thomas J. Bliley, Jr. have submitted questions and requested that they be answered for the hearing record:

Congressman Lehman

1. In your testimony, you have noted the stigma attached to child abuse. How can we help abusers and potential abusers confront their problems more forthrightly in light of community attitudes?

2. What are some of the special problems you and your colleagues face in trying to prevent the problems of child abuse in a major urban center like New York City? How are they or might they be addressed?

Congressman Bliley

1. In your testimony, you say that battering is the last phase of the maltreatment spectrum. Does that mean that by the time a child is battered for the first time, he has probably been experiencing other, less visible, forms of abuse for some time?

2. You say that child abuse has been increasing at a rate of about 15% per year. Do you mean 15% per year over the past few years, or over a longer period of time, such as 10 or 15 years? What is the reason for the increase?

3. Are the parents of children in the crisis care nursery referred to any self-help groups, such as Parents Anonymous? If not, why not?

Let me again express my thanks, and that of the other members of the committee for your testimony.

Sincerely,

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

GM/j

Enclosures

The New York Foundling Hospital | Center for Parent and Child Development

1175 THIRD AVENUE, NEW YORK, N.Y. 10021 / TEL: (212) 879-3060 / 472-2233

Office of the Medical Director
Vincent J. Fontana, M.D.

May 21, 1984

George Miller
Chairman
Select Committee on Children,
Youth, and Families
Room H2- 385 House Office Building Annex 2
Washington, D.C. 20515

My dear Chairman Miller,

I have enclosed at your request an edited transcript of my remarks made at your Committee hearing in Washington on March 12, 1984. In addition I have submitted answers to the questions requested by Representatives William Lehman and Thomas J. Bliley, Jr.

I do hope and pray that the information gathered by your Committee will provide the needed stimulus and direction urgently needed to safeguard the health and welfare of our nation's children and families.

I wish once again to express my gratitude to you and the Committee for having given me the opportunity to be of help in this important matter.

Respectfully,

Vincent J. Fontana, M.D.
Medical Director

VJF:ea

Encl.

Responses to Questions Posed by Congressman Miller

1) In your testimony, you have noted the stigma attached to child abuse. How can we help abusers and potential abusers confront their problems more forthrightly in light of community attitudes?

This is a tough question, which suggests a double response, directed at both the community and parents. It also involves how we professionals portray the problem of child maltreatment. Twenty fifteen, and perhaps even ten years ago, we used pictures of abused children to dramatize the seriousness of the problem and to overcome widespread reluctance of many people, professionals as well as the general public, to acknowledge the existence of child abuse and neglect. Many of us have pulled away from this approach, now that child maltreatment has been widely recognized as an important social reality and problem. This old approach, if still used with the general public, only inflames resentment against parents and reduces the chance that fearful parents will seek help.

Unfortunately, the approach taken by the media frequently is inflamatory, especially in its coverage of bizzare or horrendous cases, which constitute a very small proportion of the total child protective services caseload. For example, out of more that 50,000 children reported as abused or neglected in New York City each year, between 100 and 150 die from abuse or neglect, but fatality cases are likely to receive widespread coverage and present a misperception of all abusing parents as monstrous sadists or criminals. It is very difficult to get the media to present a more temperate -- and more realistic -- picture of the total phenomena of child abuse and neglect.

This problem is compounded when a child fatality occurs in a family which has been previously reported for suspected child abuse or neglect; such cases appear to mean that the system failed in its obligations to protect children. Misjudgements may have occurred in some or many of these cases, which now give everyone an easier hindsight assessment. Talking about the wider contexts of child maltreatment and the problems in providing adequate child protective services is very difficult in such circumstances -- one appears, or can be made to appear, as an apologist for the system or a participant in a cover-up. As an example, least week in New York City, the Inspector General of the Human Resources Administration issued a report examining 21 cases in which an employee of the child protective service made claims of agency mishandling or malfeasance; eight of the cases involved child fatalities, going back to 1978. There was massive news media coverage, some of it sensationalized. One result was the attached letter to the editor of a Long Island paper, condeming parents who abuse their children.

I would suggest the following remedies: (1) working with the media to portray more sensitively the human dimensions of child abuse and neglect, not the sensational aspects. The TV movie, "Something About Emelia," about sexual abuse, is an example of a positive media impact on a very disturbing and disruptive type of child abuse. (2) public awareness campaigns which emphasize, not merely reporting or protecting children, but the conditions or problems of parents which lead to abuse or neglect; (3) public campaigns and media programs designed to reach parents and to encourage self- referrals; (4) the establishment of services capable of handling such self-referrals, which otherwise would be a cruel hoax; (5) differential handling by child protective agencies and law enforcement agencies when parents voluntarily seek help and are then reported as a consequence. The recent California case in which a step-father sought help for sexual abuse, was then reported and prosecuted, and his step-daughter was detained or incarcerated as a recalcitrant material witness illustrates the need to build administrative and proceedural safeguards for parents who voluntarily seek help on their own. They should not be treated as if someone else reported or turned them in.

2) What are some of the special problems you and your colleagues face in trying to prevent the problems of child abuse in a major urban center like New York City? How are they or might they be addressed?

Coordination, communication, and cooperation become difficult in a large urban center such as New York City. I do not know how representative our problems may be other other large urban centers, but these issues have been endemic to protecting children in many communities throughout the United States, even in places which are not classified as large urban canters. Although these issues become magnified as more individuals become involved in a social problem, there is another reason for this issue, which is independent of geographical or demographical size.

The phenomena of child abuse and neglect are multi-faceted, and the intervention system required to respond, as determined by various laws and procedures, is multi-disciplinary. Doctors, nurses, psychologists, social workers, protective case workers, teachers, policemen, district attorneys, attorneys for the parents and the children, judges, probation workers, are some of the professionals who can become involved in a case. Each discipline has its own methods, perspectives, and biases. Many of these disciplines are antagonistic to each other, and they operate in different systems which may contest over turf or territoriality concerns.

The multi-disciplinary approach many of us have recommended during the last ten years or so has been proven effective, but it is not as widespread as the literature depicts -- it is an ideal more than a reality.It has been easier to implement in smaller communities where the innate closeness and cooperativeness of professionals and citizens may be greater. Size, the number of reported cases, the number of professionals, is a frequent explanation for why the multi-disciplinary approach has not been implemented in New York City as a regular mechanism for handling cases. Such multi-disciplinary teams do exist in the City, but they discuss only a handful of cases. They do present greater problems of administrative coordination in a large urban center, but I am not convinced this is an insuperable obstacle. The average caseload of individual social workers, lawyers, doctors, etc., is not necessarily larger in New York City; indeed, the average caseload per CPS worker appears to be smaller in New York City than in many smaller communities -- we have not experienced reductions in CPS staff, which has actually been increased during Mayor Koch's administration.

The City, as well as the Mayor's Task Force on Child Abuse and Neglect and an inter-agency planning committee established by the Human Resources Administration and the Deputy Mayor for Operation's office is begining to look at ways to improve the relationship between child protective services and the various professional disciplines involved in reported child abuse and neglect cases. The antagonisms, distrust, and doubts about the efficacy of CPS intervention have to be addressed before we can truly establish a multi-disciplinary approach to child protection. CPS needs to be sufficiently improved to convince professionals and the public that children can be protected and parents helped. This will be necessary to maintain public support for the social services approach, rather than alternative approaches such as law enforcement, to child protection.

These issues also affect the establishment of prevention programs. Through the Islands of Safety, we have begun a program to help parents in crisis, parents on the verge of child maltreatment, or self-referring parents who have already abused or neglected a child. More general preventive programs, which deal with underlying societal trends or values which may affect the occurrance of maltreatment are more difficult to demonstrate effectively -- there is less societal acceptance of them. A promising area is parent education, of which there are two types: (1) purely dydatic programs for school children or for adults; and (2) theraputically oriented programs for troubled parents with or without an abuse or neglect problem. We are beginning to work towards the development of such programs. A Citizens Task Force, jointly chaired by the wife of Governor Cuomo and the State Commissioner of Social Services, has made this its top priority.

The theraputically oriented parent education programs may also be able to play a crucial role in reuniting families whose children have been placed in foster care. There is increasing concern that the efforts, nationally and within the states, to reduce foster care may endanger children by keeping them inappropriately with their parents or returning them home prematurely. There have been some fatality cases in which this was an issue. Many foster care programs currently do not have the programatic means of dealing with parenting issues -- an underlying reason for placement. When the children are in placement, there is no way to measure any change or improvement in the parenting skills of the parent; as a result, psycho-social assessments or judgments are made without critical data on parenting skills. The theraputical oriented parent education programs may be able to fill this critical gap in child welfare assessment and planning for children; these programs could be an important means of safely reuniting families. We are looking at this issue and may recommend a demonstration program to test the feasibility and necessity of incorporating theraputic parent education programs into all foster care or substitute care programs.

3) In your testimony, you say that battering is the last phase of the maltreatment spectrum. Does that mean that by the time a child is battered for the first time, he has probably been experiencing other, less visible, forms of abuse for some time?

In some cases, the degree of physical abuse escalates over time, becoming more severe as the child grows older or the problems afflicting the parent increase or the parent's coping abilities are progressibely overwhelmed or weakened. This does not happen in all cases; some cases begin with high, near fatal, or fatal abuse from the begining or very early in the life of the child, including new borns. The spectrum or continuum model of abuse includes this aspect.

This model also acknowledges that issues of abuse and neglect may occur in the same family or happen to the same child. According to the American Humane Association, between 17% and 24% of protective service cases involve "multiple maltreatment" (the range varies depending upon who the child's careteker is). The spectrum or continuum model reflects the mixture of abuse and neglect in some cases.

This model is also used to indicate a linear progression in severity of abuse as well as neglect. In some cases, the degree of severity, in terms of condition or consequences, may remain constant although chronic. In such cases, different children or families are considered to be at different points in the continuum, or different parts of the spectrum. The model thus describes the totality of the phemomena of child abuse and neglect in terms of different degrees of severity.

4) You say that child abuse has been increasing at a rate of about 15% per year. Do you mean 15% per year over the last few years, or over a longer period of time, such as 10 or 15 years? What is the reason for the increase?

The American Humane Association, which has been collecting data on reported cases since 1976 has found that the "magnitude of the increase from year to year is actually decreasing." The AHA reports the following increases since 1976: (1) 25% increase in 1977 over 1976; (2) 19% increase in 1978; (3) 16% increase in 1979; (4) 11% increase in 1980; and (4) an 8% increase in 1981. The AHA offers the following analysis:

> The apparent levelling off of reporting follows a period of rapid development of state reporting systems, during which the total number of reports was sensitive to the introduction of new state legislation and policy. For example, neglect was not considered a reportable condition in all jurisdictions until 1979. While state systems continue to change, the changes are more a matter of refinement in technology than addition of new reportable conditions.

There is merit to this analysis. It is important to note that my reference to increases is over time and that when I talk about protective service caseloads, I am including abuse as well as neglect cases, as is the AHA. I am not imtimately familiar with the methodology of the AHA, but I do know that an increasing number of states have been providing them with data since 1976. I assume they have taken this into account in computing the rate of annual incrases in reports. New York State has had a consistent reporting law, involving both abuse and neglect, since 1973. The following table shows the pattern of increases in New York State since 1974, the first full year of the operationalization of the new law.

Year	Total Reports	Change	Total Children Reported	Change
1974	29, 912		59,636	
1975	30,990	+4%	63,365	+6%
1976	37,698	+22%	73,288	+16%
1977	39,682	+5%	75,762	+3%
1978	45,337	+14%	85,640	+13%
1979	51,842	+14%	92,404	+8%
1980	55,937	+8%	97,483	+5%
1981	64,421	+15%	112,662	+16%
1982	69,739	+8%	120,207	+7%

Based on our experience in New York State, it seems accurate to say that during the last 8 years, there has been an annual increase of about 15%. I would note that there have been sharp flucuations from year to year, which no one has explained. I can surmise that the increase in the rate of the increase in 1981 reflects the state take-over of the central register in New York City because the state accepts more reports than the city, which performed a heavier or stronger screening. The important fact is that the increase continues and shows no sign of abating. There has not been a decrease in one single year since the 1973 law was implemented. From 1974 to 1982, the number of reports state-wide has increased 133%, and the number of children reported has increased 101%.

There is a strong potential for continued increases in reported cases. The National Incidence Study estimated the professionals who report cases do not report 62% of the abused or neglected children known to them. We have no estimates for non-reporting among average citizens -- family members, relatives, friends, neighbors -- who make between 40% and 60% of all reports, depending upon the state. The impact of increased reporting during a time of budget and staff reductions in many communties raises a serious challange to our commitment and capacity for protecting endangered children. The rate of unfounding reports has been increasing; cases are being closed quickly, and investigations are delayed. In some areas, the telephone, rather than a home visit, has become a prime investigative tool. We can expect the impact on the lives of children to become more apparant in the years ahead.

The reasons for these increases are a source of speculation. The implementation of new reporting laws and public awareness campaigns certainly have played a major role. Greater recognition of child maltreatment, greater willingness to do something about it also have made a contribution. There is also the likelihood on an increasing incidence, although the evidence is not clear. The stress model widely used to explain the causes of abuse and neglect leads us to expect that when unemployment increases, when the family is under greater change stresses, when social values are in flux, that abuse and neglect are likely to increase as well.

5) Are the parents of children in ~~the~~ crisis nursery referred to any self help groups, such as Parents Anoymous? If not, why not?

When such groups exist in the neighborhoods where the parents live, such referrals are made. Parents Anonymous is not firmly established in New York City, for a variety of complicated reasons, and a new effort to do something is just begining.

We have found referrals to parent aid programs and parent education programs, as well as to traditional family services and counselling programs to be effective. Some of these programs have self-help components.

NEWSDAY, SUNDAY, MAY 6, 1984

Letters

Face Up to Child Abuse

Lately the media has been full of gruesome stories regarding child molesters and child abusers. These stories are not new. It has become a "hot item" and it is finally being given the attention that is so long overdue.

As a mother of two youngsters, it scares me to death to think that anyone, anywhere, can fall victim to these sick, vile people. Who is safe? When I was a child, people didn't have to worry to the extreme degree that we do in today's society.

I urge all parents to educate their children against the possible consequences of talking to strangers, etc. Every elementary school should institute a program to educate young children about these dangers.

Of course, no one wants to frighten children, but perhaps something in the form of play-acting or a puppet show can get the message across. Afterward, a thorough question and answer period with trained personnel would be helpful.

At the very least, when a person is convicted of this most heinous crime, he must be quarantined from the rest of society; the opportunity of parole must not exist. Too many times I have read about a child molester / murderer who has had a previous record of such crimes.

My personal opinion is that the death penalty should be reinstated for the animals who commit these horrendous acts.

For those of you who would disagree, let me suggest that you investigate and perhaps listen to the confessions of these criminals. Look at the police pictures of the broken and often sexually mutilated little bodies of those defenseless children.

If this letter sounds harsh to some, it was meant to be. This is not a pretty subject and it must be dealt with, since it is not likely to go away.

June M. Harris
Huntington

City of
Norfolk
Department of Police

April 25, 1984

Ms. Karabelle Pizzigatti
The House Select Committee on
Children, Youth & Families
Room 385
House Annex #2
Washington D.C. 20515

Dear Ms. Pizzigatti:

I am forwarding our Family Sexual Trauma Team Project Report for April 1 1981, to June 30, 1983, at the request of Fae A. Deaton, Community Mental Health Center Associates.

If I can be of any further assistance please let me know.

Sincerely

P.L. Richardson

P. L. Richardson, Lieutenant
Acting Commanding Officer
Youth Division

PLR/bn

Enc.

Post Office Box 358 • Norfolk, Virginia 23501

FAMILY SEXUAL TRAUMA TEAM

PROJECT REPORT

4-1-81 to 6-30-83

PREPARED BY:
KAREN DEGOLIA WEBER
PROJECT COORDINATOR
NORFOLK POLICE DEPARTMENT
NORFOLK, VIRGINIA 23501

Introduction

The Norfolk Family Sexual Trauma Team utilizes a multi-disciplinary team approach to dealing with intrafamily sexual abuse of children, and is designated as the primary investigative unit of such abuse for the city of Norfolk. This team is comprised of Child Protection Workers, Police Investigators, and Commonwealth Attorneys. For each reported case, the investigative "team" consists of one Child Protection Worker and one Police Investigator. The team utilizes existing community resources and works cooperatively with schools, psychiatric treatment teams, probation officers, hospitals, Parents United and the military.

Due to lack of coordination between Child Protective Services and the Police Department in the investigation of incest cases, clarification regarding reporting and investigative procedures was indicated. A need was identified for the two agencies to work together and standardize procedures in order to provide more comprehensive and well-integrated services to the families involved.

The concept was designed to involve both the Police Department and Child Protective Services in investigations from the outset, and to provide coordination of services between and among all disciplines involved.

History

Statistics for 1980 showed 55 reports of child sexual abuse to Department of Social Services, with no indication as to whether these were founded or what intervention or services were provided. Corresponding statistics from the Police Department for the same year showed five arrests for child sexual abuse with no indication of the eventual outcome.

Several factors were involved regarding this discrepancy. A reciprocal reporting law between DSS and the police is non-existent in the Commonwealth. Child Protective Services is mandated by law as the agency which investigates child abuse and neglect. By law, this agency has the discretion of not reporting abuse or neglect unless it is a Class V felony or above. Child Protective Services exercised this prerogative in good faith in the belief that services could be provided to the families involved without the intervention of the courts. The fallacy of this belief system lies in the very nature of the crime itself, the personality characteristics of the offenders, and the dynamics of the dysfunctional family unit. This incestuous activity cannot occur except in secrecy. The offenders are most often secretive, manipulative, coercive and rely on the lack of concrete evidence and the fact that often their spouses will protect them. Even when they admit to the problem, there is no way to enforce continuance in a long-term treatment plan or to adequately monitor the child. Case histories show that this is compulsive behavior and does not dissipate simply because it has been uncovered. For those convicted, usually a short prison term is received, after which the offender returns home to continue the abuse only to go to great lengths to ensure it remains secret. Either way, the child remains the loser, and suffers deep and long-lasting emotional damage.

Being aware of the dynamics of the incestuous family, the two departments agreed to rethink the entire process and through careful planning and research formulated the following objectives:

1. increase reporting to both departments
2. utilize a team approach to investigations
3. prosecute all offenders
4. remove the offender from the home rather than the child
5. eliminate, or reduce the probability of, the child testifying in court
6. rehabilitate offenders
7. provide therapeutic intervention for the child and other family members
8. stabilize and reunite family units
9. provide long-term follow-up to prevent further sexual abuse.

To incorporate these concepts into a viable framework, a highly specialized unit was needed; readily identifiable by the public as supportive and not punitive, and easily accessible to all professionals within the community. As a result, the Family Sexual Trauma Team was formed and originally was comprised of two police officers, six social workers, one prosecutor, one coordinator and one director. To achieve the goal of community-based multi-disciplinary intervention in intrafamily child sexual abuse, the following procedures were implemented.

An extensive community outreach program was begun to educate the public as to the problem and the means by which to effectively deal with it. This was accomplished through ongoing multi-media presentations via: newspaper, public service announcements on the radio, radio and television talk shows, special television documentaries, massive pamphlet distribution, a speakers bureau, and training and education programs for agency professionals.

Team members were provided with extensive training in the dynamics of child sexual abuse, special interviewing techniques, psychology of the victim and offender, communication skills, and ethical and professional issues.

Intake and working procedures were developed and the investigative teams began working in tandem from point of intake to final court disposition. This eliminated successive and repetitive questioning of the victim and prevented the offender from colluding with the victim and other family members. This technique provided an unpredicted benefit. When offenders are interviewed (without prior knowledge of the report), they more readily confess which eliminates the necessity for the child's testimony in court. It simplifies the prosecution process, and provides the necessary initial component of successful rehabilitation, which is to admit that a problem exists and begin to take responsibility for their actions.

Through the cooperation of the prosecutor and the courts, and based on the recommendations of the psychiatric treatment teams, offenders were able to be considered for treatment as a condition of probation rather than incarceration. Although they remained outside the home with no contact with the child, they were required to attend Parents United, continue in therapy as long as deemed necessary by the treatment teams, and support their families if head of the household. Therapeutic intervention provided a means for family members to assimilate the trauma, gain knowledge and understanding of the dynamics involved, begin to relate to one another in new ways and reunite as a family unit at some point.

Program Overview

The purpose of a coordinated multi-disciplinary approach is to provide a consistent, empathic and effective method of dealing with intrafamily child sexual abuse. The primary concern of all team members is the emotional and physical well-being of the child as a member of the family unit. Any and all actions taken are based on this premise. The team members are goal oriented toward prompt investigation and service delivery, skilled and sensitive treatment of the child and other family members, and providing additional resources or referrals when needed.

The focus of the Police Department is to investigate and determine the extent of the allegations, and when founded, to identify, charge and arrest the offender. The focus of Protective Services is to investigate, ensure protection of the child and to provide family assessment and case management.

The team usually responds within 24 hours to any complaint received. Through skilled and sensitive interviewing, the alleged offense/s are determined to be founded or unfounded, and medical/legal evidence collected when appropriate. The combined investigative procedures from the perspectives of social work and law enforcement produce a complete and comprehensive profile of each member of the family unit.

Initial contact is made either to Child Protective Services or the Police Department by the child, family member or other outside source. The agency team member first receiving the call immediately contacts the other team member and the two work in tandem from this point on. The complainant is interviewed, the child, other family members, any other relevant individuals, and the offender. If the allegations are founded, the offender is charged and arrested as prescribed by state law or city ordinance as determined by the investigation. The child remains in the home whenever possible, provided the atmosphere is supportive.

The focus of the Commonwealth Attorney is to prosecute the offender. It should be noted that the Commonwealth Attorney has no authority over a case until the defendant is actually charged with a criminal offense, is by law the official elected to make the decisions on how a case is to be prosecuted, and represents the Commonwealth of Virginia and in this capacity seeks to protect not only the victim but also the public in every way reasonably possible. In the Norfolk courts the prosecution of criminal cases is on a case-to-case basis, and each case is considered in light of its own peculiar aspects. The initial hearing in Juvenile and Domestic Relations Court is held the following weekday morning. The court's function is to decide whether a crime has been committed and to impose punishment. At initial court hearings, it will be the general policy that the team recommend any one of the following:

1. the offender reside elsewhere other than the home
2. the offender have no contact with the child
3. the offender participate in evaluation and prescribed treatment with the treatment team
4. the offender participate in Parents United
5. the offender, when head of the household, provide financial support to the family.

To be a candidate for diversion, to be rehabilitative treatment as an alternative to incarceration, the offender is required to be cooperative to the fullest extent with all disciplines involved in the investigation, disposition, evaluation and treatment, prosecution and monitoring process. Cooperation constitutes:

1. admitting that a problem exists
2. admission of the offense through a verbal and signed agreement
3. agreement to evaluation and treatment
4. adherence to conditions of bond
5. waiver of preliminary hearing
6. agreement to plead guilty as charged
7. full compliance with conditions of probation.

The focus of the psychiatric treatment teams is to provide therapeutic intervention and supportive services to facilitate rehabilitation of the offender and stabilization of members of the family unit. Child, family members, and offender are initially involved in individual counseling, which eventually leads to combined family therapy. The therapists work closely with the probation and social services to ensure the welfare of the child.

Medical examination for the child is scheduled when deemed necessary to provide treatment of injured and/or diseased children, and to preserve medical/legal evidence.

Following completion of the judicial process, Probation Departments follow the offender to ensure that conditions of probation are met. The threat of incarcertation in most instances is the impetus that will cause the offender to participate in and accept psychiatric treatment, prevent committing further acts of sexual abuse, and assume a more appropriate parenting role.

Parents United, Daughters and Sons United, and Adults Molested As Children meet weekly, and through small group interaction provide support and self-awareness in a therapeutic setting for all family members. These groups work in conjunction with the therapists but not as a substitute for psychiatric treatment. Attendance is mandatory for perpetrators and is monitored by the Probation Department.

The project coordinator ensures coordination of investigation, disposition and follow-up of all cases and acts as a liasion between cooperating community agencies as well as the primary discipline involved.

By identifying common goals, comprehensive and well-integrated services to the child victim, family members and offenders are ensured.

Policy & Procedure Assessment & Redirection

During the first year of the project many changes occurred as a working knowledge was acquired. Strengths and weaknesses were assessed via monthly staff meetings.

Although the investigative teams and procedures were in place and the function was working smoothly, it soon became apparent that the project was falling short of its original goals. A need was identified to re-examine policy and procedure, and clearly define goals and objectives.

One main problem was that the majority of cases were handled through Juvenile Court, with no assigned probation officers to supervise conditions of probation for offenders. Since Social Workers were assigned as case managers, they were also relegated the task of monitoring conditions of offender probation as well as monitoring the child and family. This proved to be an unworkable concept, as it put the social worker in the dual role of both child advocate and offender probationer, creating role confusion for both worker and client. As the caseload increased, it also became logistically impossible to adequately monitor the numbers of people involved. Subsequently, all felons were bound over to Circuit Court, and cases involving a misdemeanor and remaining in Juvenile Court were assigned to Juvenile Probation. A mechanism was designed to backtrack and assign probation to offenders not followed in the past.

In conjunction with enforcing probation, Parents United had not developed a system of verifying attendance or absences at required meetings. Therapists needed clarification as to what was expected of them by the court as well as a mechanism to terminate therapy when appropriate. It was brought to the attention of the Commonwealth Attorney that known violations of probation were not being reported nor did there seem to be a mechanism to deal with this.

The key factor involved here was a need for better communication between all disciplines and the probation officer. It was agreed that any needed changes in conditions of probation or violations of probation needed to be brought to the attention of the court and coordinated through the probation officer assigned.

Strengths & Weaknesses:

Currently, two Police Investigators and two Child Protection Workers are assigned to the investigative team. The Commonwealth Attorneys are assigned on a rotating basis under the supervision of the Head of the Juvenile Division. Probation officers are assigned through two specific supervisors. The psychiatric teams are assigned on a rotating basis by the social workers.

Coordination of this project has been difficult from the outset. Although a mechanism for coordination was supplied, it soon became unworkable. Each agency had a preconceived notion of their role with the Trauma Team and remained protective of their turf in terms of past policies and procedures. This does not allow the flexibility needed for the cooperative effort required of a multi-disciplinary team. Within the coordination function, there is no role of authority or place in the decision making process. The advantage of this is it requires and ensures a democratic policy making process. However, the disadvantage is that no one person or group has the final vote as to any particular policy or procedure. If all agree, a workable system exists. If any one agency disagrees and chooses not to adhere to group consensus that agency ultimately impedes the functioning of the unit as a whole and becomes a negative controlling factor in the team concept. The current thrust is to facilitate inter-agency cooperation and provide community awareness, professional staff training, and prevention programs.

Although the commanding officers of the Police Department initiated the project and have been extremely supportive, most of the investigators in the Youth Division have been resistant to change and have not been willing to accept the new investigative techniques or endorse the concept of rehabilitation as opposed to incarceration. The Division of Social Services has been reluctant to relinquish control as case managers and are inconsistent in their policies regarding the investigation of these cases. However, the four individuals who are currently assigned to the investigative teams are motivated, highly skilled, sensitive and cooperative, and are indicative of the highest quality of professionalism available within each department.

There is a fairly rapid rate of turnover among the Commonwealth Attorneys in the Juvenile Division, and there has been some reluctance to provide training to familiarize these attorneys with the dynamics of intrafamilial child sexual abuse and the workings of the project itself. However, the head of the Juvenile Division has developed a unique policy for handling these cases, wholeheartedly supports the concept of rehabilitation of offenders, and is willing to support Probation Department on violations of probation. Few children have been required to testify in court, and whatever the prosecution does is consistently in the best interest of the child involved.

The psychiatric treatment teams are highly competitive as a segment of the health care industry and rely on the team social workers for referrals. Although each of the three facilities have agreed to accept clients with no financial resources, there is no equitable system of referral for these indigent patients. Subsequently, certain facilities may at times be overloaded with such clients, which does not allow for adequate continuity of care. The more positive aspect of all the psychiatric facilities utilized by the team is the quality of services available. Each facility is well staffed with licensed and highly skilled professionals who have a great deal of expertise in the evaluation and treatment of child sexual abuse.

Parents United of Norfolk has had difficulty in communicating with the coordination component of the team, which is indicative of some in-house malfunction. On the other hand, the benefit provided by the organization in terms of support for its members in a non-threatening atmosphere is invaluable. As there are Parents United chapters in two adjacent cities, offenders are allowed to attend meetings in other communities in order to fulfill their probationary obligation for mandatory attendance.

The Probation Department follows offenders closely. The staff is aware of the personality dynamics in terms of the manipulation and denial which occur, and are not reluctant to strictly enforce conditions of probation. Their role is clearly defined and services are well coordinated with interdisciplinary agencies.

Through the comprehensive coordination efforts of this project, a Primary Prevention Project has been developed for students in the Norfolk Public Schools, grades kindergarten through sixth. A pilot project was implemented in six schools and received an overwhelmingly positive response from administration, teachers, parents and students. The evaluation was conducted by two individuals, one from Media Services and one from Health and Physical Education. This program utilizes the film "Who Do You Tell?" in conjunction with a teacher training videotape, and will be incorporated as a regular part of the curriculum in the fall of 1983 for annual presentation to grades one, three and five. Although there is no way to accurately measure the impact of such a prevention program, hopefully many incidents will be prevented which otherwise may have occurred or continued undetected.

Quarterly interagency conferences have been an integral part of the coordination of services. These conferences have provided a means for improved working relationships by allowing team agencies to interact with one another, address problem areas, and strengthen existing workable policies.

Through the auspices of this highly specialized multi-disciplinary team approach to child sexual abuse, reporting has increased drastically, it has improved service delivery to the population it addresses, and has increased the cooperative efforts between and among the agencies involved. A flow chart is included in Attachment A. Statistics for the period 4-1-81 to 6-30-83 are included in Attachment B. Cost effectiveness has been realized by utilizing existing community resources wherever possible. The cost reduction to the Department of Corrections in terms of non-incarceration alone is of interest. Current estimated cost of providing residence in a secure facility for one year is $26,000 per individual. With 63 individuals diverted from incarceration, a cost reduction of $1,638,000 has been realized.

Conclusions & Recommendations:

Sexual Abuse is one aspect of the misuse of children within the broad spectrum of child abuse and neglect. The individual and family dynamics, however, are unique in both the origin and manifestation. Subsequently, it is the recommendation of the coordination component of this project that all child sexual abuse, particularly that occurring within the family, be treated as a separate and distinct entity, and that the investigation and intervention remain specialized to facilitate a process which is preventive and curative, not punitive, and to protect the best interests of the child.

It should be noted that this is not just a special interest group, but a collective of individuals, both child and adult, who are faced with very unique life circumstances and special needs. The readily observable family dysfunction is not a result of the incestuous activity, but rather the incestuous activity is a result of a dysfunctional family unit; comprised initially of adults who are exhibiting maladaptive behaviors as a coping mechanism as a result of their own incomplete personality development.

As this type of activity is clearly criminal behavior, as described in the statutes of the legislative Code of Virginia, it becomes necessary to incorporate the total intervention process as a function of the criminal justice system. This by all means does not exclude, but clearly indicates the need for inclusion, of the human services and resources component, which is concurrent with the philosophy of the Juvenile Court in regard to providing the wide range of services which are necessary to juvenile victims of crime. This philosophy reinforces the importance of maintaining a multi-disciplinary approach to this complex issue.

Due to the complexity of the coordination process involved in such a venture, it seems most feasible to implement an official policy to accommodate a Trauma Team Case Conference on a monthly basis. This policy would demonstrate a conscious and cooperative, and highly visible effort within the community toward responsible action on behalf of these victimized and traumatized children. The main function of a monthly Case Conference would be to review new cases, staff cases pending adjudication and provide follow-up on cases after final court disposition. The emphasis would be on the child rather than the offender. This Trauma Team would be comprised of one representative from the following agencies and appointed by their respective agency: (1) Police, (2) Child Protection, (3) Commonwealth Attorney, (4) Participating psychiatric facilities, (5) Juvenile Probation, (6) Adult Probation, (7) Parents United, (8) Public Schools, (9) Naval Regional Medical Center. The Team Coordinator should be appointed from within the representation, and be responsible for chairing the conference and facilitating interagency communication and cooperation.

Further Recommendations Include:

1. Implementation of a Child Abuse Unit within the Police Department with Child Protection workers assigned to the Unit to ensure con-

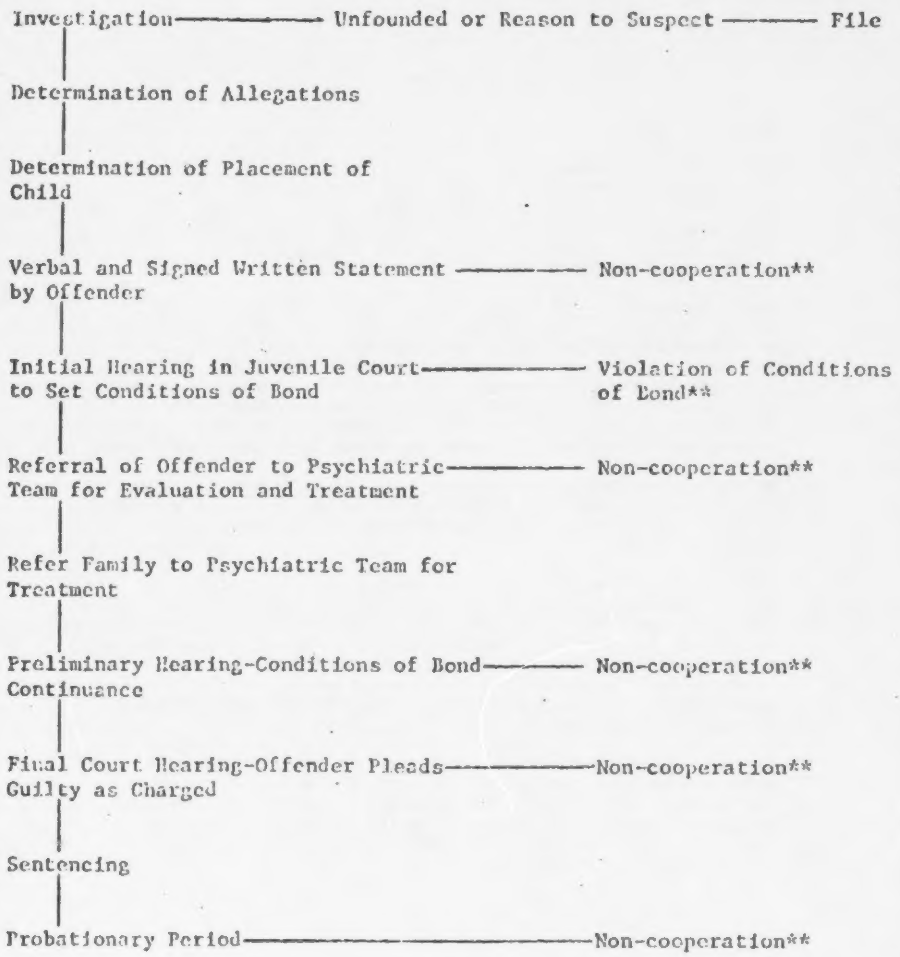
tinuance of the specialized investigative procedures already in place. This Unit would provide for the overlap of extreme or difficult physical abuse cases which currently are channeled to the team, but with no mechanism for official procedure.

2. Explore the feasibility of establishing a Child Sexual Abuse Treatment component through the courts. This Unit would have the capability providing offender evaluation, diagnostic services for child victims and individual and group therapy for all family members. This type of service could readily address the growing problem of needed services for families who do not have the financial resources for privately contracted psychiatric care. It should operate in conjunction with, but not in replacement of, Parents United. As there is a great deal of expertise within the private sector in the treatment of child sexual abuse, it would seem logical to contract for services from within these specialized facilities. Currently, the individuals referred for psychiatric treatment by the Trauma Team are receiving individual therapy. The benefit derived from group therapy, and the subsequent peer interaction and positive role models provided by co-facilitators has been well documented by clinical professionals utilizing this concept. It is recommended that a committee be formed to explore the mechanism and funding sources available to implement such a concept. The committee should be a representative of: the State or National Parents United organization, the local Parents United organization, each private psychiatric facility currently utilized, Juvenile Court Judges, Department of Social Services, Juvenile Probation, Adult Probation, Navy Family Advocacy Program.

3. Provide a group home facility for sexually abused children whose best interests are served by removal from their homes. Due to the special needs of these children, particularly adolescents, traditional foster care and currently existing group home facilities for children with behavior disorders is not adequate. This type of facility can best meet the needs of these children if they are placed in a non-threatening and supportive environment with a therapeutic milieu.

   Individual and group therapy could be provided in-house and/or in conjunction with the proposed Child Sexual Abuse Treatment component. Currently, children placed in foster care, homes of relatives, and group homes must be transported by Trauma Team social workers to and from individual therapy. This is an indiscriminate, time-consuming and inappropriate use of highly skilled professionals with increasingly heavy caseloads. Most likely, the implementation of this type of facility would fall under the purview of the Department of Social Services or the courts.

FAMILY SEXUAL TRAUMA TEAM
PROCEDURE



Investigation — Unfounded or Reason to Suspect — File

Determination of Allegations

Determination of Placement of Child

Verbal and Signed Written Statement by Offender — Non-cooperation**

Initial Hearing in Juvenile Court to Set Conditions of Bond — Violation of Conditions of Bond**

Referral of Offender to Psychiatric Team for Evaluation and Treatment — Non-cooperation**

Refer Family to Psychiatric Team for Treatment

Preliminary Hearing-Conditions of Bond Continuance — Non-cooperation**

Final Court Hearing-Offender Pleads Guilty as Charged — Non-cooperation**

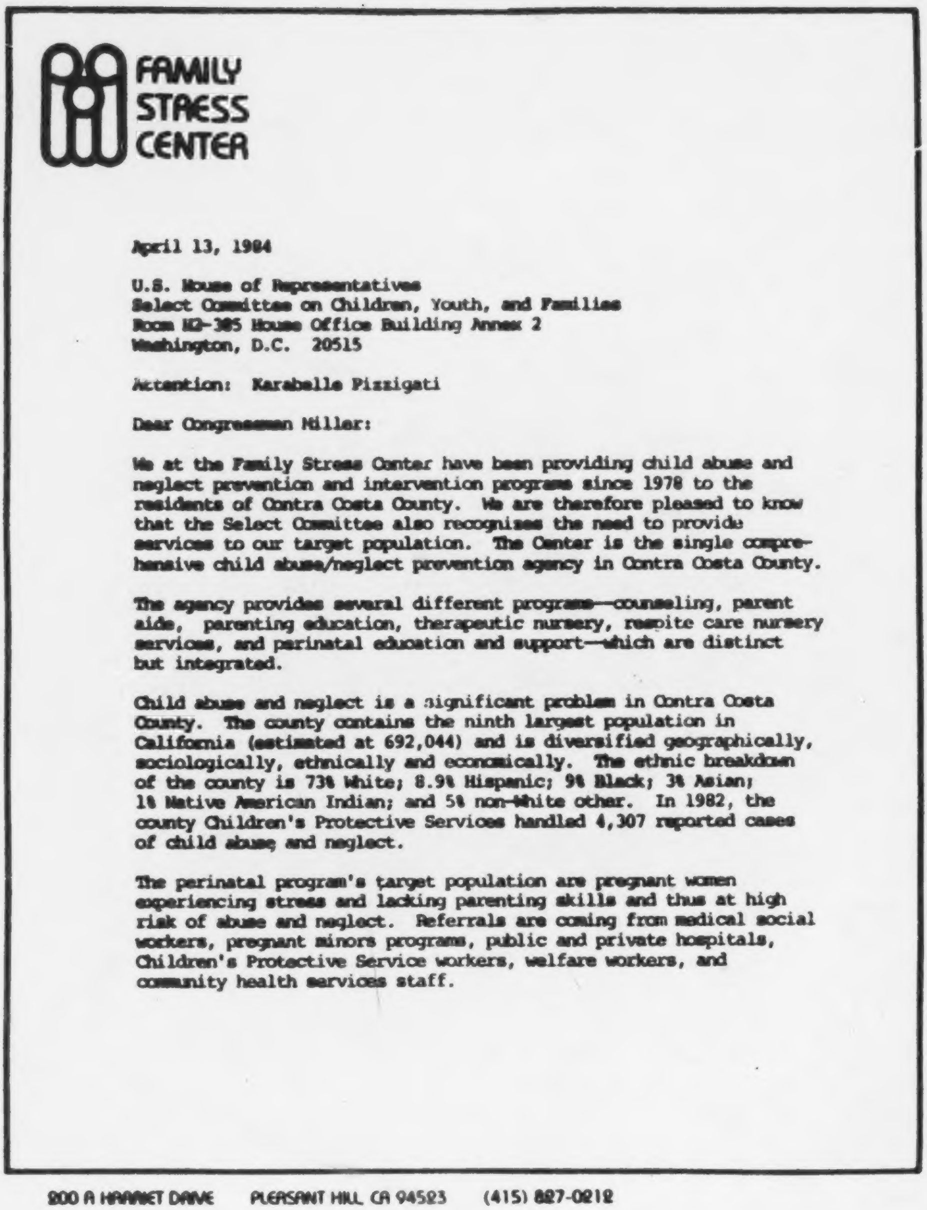
Sentencing

Probationary Period — Non-cooperation**

**Due Process

Prosecution

Incarceration



FAMILY
STRESS
CENTER

April 13, 1984

U.S. House of Representatives
Select Committee on Children, Youth, and Families
Room H2-385 House Office Building Annex 2
Washington, D.C. 20515

Attention: Karabelle Pizzigati

Dear Congressman Miller:

We at the Family Stress Center have been providing child abuse and neglect prevention and intervention programs since 1978 to the residents of Contra Costa County. We are therefore pleased to know that the Select Committee also recognizes the need to provide services to our target population. The Center is the single comprehensive child abuse/neglect prevention agency in Contra Costa County.

The agency provides several different programs—counseling, parent aide, parenting education, therapeutic nursery, respite care nursery services, and perinatal education and support—which are distinct but integrated.

Child abuse and neglect is a significant problem in Contra Costa County. The county contains the ninth largest population in California (estimated at 692,044) and is diversified geographically, sociologically, ethnically and economically. The ethnic breakdown of the county is 73% White; 8.9% Hispanic; 9% Black; 3% Asian; 1% Native American Indian; and 5% non-White other. In 1982, the county Children's Protective Services handled 4,307 reported cases of child abuse and neglect.

The perinatal program's target population are pregnant women experiencing stress and lacking parenting skills and thus at high risk of abuse and neglect. Referrals are coming from medical social workers, pregnant minors programs, public and private hospitals, Children's Protective Service workers, welfare workers, and community health services staff.

200 A HARRIET DRIVE PLEASANT HILL, CA 94523 (415) 827-0212

The criterion used for referring into the program are: pregnancy, unplanned or unwanted; social, geographic or linguistic isolation; age; marital status; history of abuse; drug/alcohol abuse; low self esteem; chaotic life style; poverty; underuse of community services; criminal or mental illness record; poor health or low intelligence of mother; physical disabilities of baby or problem birth.

The clients are followed by the Center's parenting consultants. Most of the visits take place in the client's own home.

At the beginning of our involvement the problems clients present are often ones of survival. The most pressing needs are for food, housing, and supplies for the new child. Low income housing, landlords that will accept a woman and a child on welfare, and a woman's ability to come up with the deposits needed to establish a home are severe problems. Many of our clients are living in overcrowded apartments, a few in shacks, cars, or moving from one house to another, staying with friends.

What we hope/expect to accomplish:

In our work with these parents we hope to increase their self esteem and parenting capabilities by using a goal-task oriented approach to problem solving. We are educating and training parents in the areas of intimacy and bonding, child development, relationships and communication, stress management, and parenting. In providing information and access to community resources, we expect to diminish the stress escalated by and stemming from demographic, linguistic and social isolation, and the lack of financial resources for adequate food, clothing and housing.

We expect to see noted improvement in participants' abilities to communicate more effectively, to form positive, intimate relationships with peers and their children, to cope with the pressures of parenting and home management.

Ultimately, we expect to dramatically reduce the incidence of child abuse/ neglect in those families receiving our services. We are working in conjunction with U.C., Berkeley, School of Social Welfare to research the effects of this kind of support program. We believe that our findings will collaborate the Colorado findings which not only showed reduction in the incidence of abuse/neglect in the group of clients receiving services, but also saved the state a substantial amount of money by eliminating the short term cost of the involvement of Children's Protective Services, criminal justice system, mental health workers, medical care and foster care costs.

The research we are conducting in conjunction with this service project will expand our knowledge of the relationships between parenting, parental stress, bonding and attachment, and the problem of child abuse and neglect. We also believe that our findings will concur with previous studies which have shown that prevention programs provided during the perinatal period are cost effective. The resultant savings will provide scarce funds now being spent on treatment, intervention, criminal justice, court costs, medical and psychological treatment expenses for the abused child as well as foster care for out of home placement.

It is time that the cycle of abuse be ended, and we are pleased that your committee is dealing with this crucial issue.

Sincerely,

Susan Hacking

Susan Hacking, Ph.D.
Child-Parent Enrichment Project
Coordinator

William A. Groth

William A. Groth
Executive Director

National Committee
for
Prevention of Child Abuse

WHAT HAVE WE LEARNED ABOUT PREVENTING CHILD ABUSE?
AN OVERVIEW OF THE "COMMUNITY AND MINORITY GROUP ACTION TO PREVENT CHILD ABUSE AND NEGLECT" PROGRAM

ELLEN GRAY, RESEARCH ASSOCIATE

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What Have We Learned About Preventing Child Abuse? An Overview of the "Community and Minority Group Action To Prevent Child Abuse and Neglect" Program[1]

Ellen Gray, Research Associate
National Committee for Prevention of Child Abuse

Introduction

Study and service in the field of child abuse, as in many other areas of effort--mental and physical health--is placing increased emphasis on prevention. The reasons are the same across all fields: the alternative course is too costly. It is costly in dollars and costly in the rate and consequences of failure. The treatment of many social and environmental problems is often a case of too little service, given too late, with too-low success rates [1].

The area of child abuse prevention is still in an embryonic stage, however. Public health concepts--the historical framework for current prevention efforts--do not translate easily to a phenomenon of multiple, and largely unknown, etiology. Professionals and volunteers are casting out in many directions to find effective and efficient ways to promote family health, reduce family risk, build anticipatory coping skills. Some of the strategies they have employed have enjoyed great public popularity (e.g. family-centered birthing practices). Others are less well known because they are newer (self-care programs for "latch-key children"); because they are in one professional system (early and periodic screening, diagnosis and treatment programs [EPSDT] in the health care system); or because they operate behind the scenes (legislative advocacy for a Children's Trust Fund on the state level). All are inadequately tested [2].

In 1979 the National Center on Child Abuse and Neglect in the Children's Bureau of the Administration for Children, Youth and Families of the Federal government embarked on a community-based prevention program to learn more about how to prevent abuse. In October of that year they awarded eleven 3 1/2 year grants to communities to conduct demonstration projects in the areas of preventive perinatal interventions; parent education; community education, information, and referral; and public awareness and education using the dramatic arts and the media.[2] The National Committee for Prevention of Child Abuse was awarded a grant to provide a collaborative evaluation of each of these programs.[3] This research has just ended and has contributed to the knowledge in the field, particularly with regard to those programs which do not require large-scale and continuing involvement of professionals.

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[1] The author wishes to acknowledge the assistance of the following people in compiling and analyzing the data: Joan DiLeonardi, Linda Barrett, John Cosgrove, Mary Kay Duggan, Sue Kulinowski.

[2] The demonstration program was entitled "Community and Minority Group Action to Prevent Child Abuse and Neglect." A brief description of each of the eleven programs is included in Appendix A.

The study employs a range of research techniques and strategies, geared to the unique character of each of the demonstration programs and dealing with the particular challenges of evaluating prevention. The following discussion summarizes the research findings by type of strategy.

Perinatal Programs

Four of the programs in the demonstration round--the perinatal programs----are variations on the theme of making the earliest possible intervention in the life cycle of the individual. The first of these strategies is early and extended maternal-infant contact. Building on research findings of readiness for interaction of mother and child right after birth [3, 4, 5], the theory has developed that successful mother-child bonding may play a vital role in preventing future parenting disturbances. Several tests of this hypothesis have suggested that 1) early and extended contact promotes attachment between mother and baby [6], 2) the enhanced attachment is still in effect and observable when the baby is a year old [7], and 3) having mother and baby "room" together in the hospital during the post-partum period results in fewer problems with inadequate parenting [8].

Following up on these studies, Vanderbilt University Medical School demonstrated with a group of young, low-income mothers and their babies, three variations of increased post-partum contact--immediate contact in the delivery room, rooming-in, and a combination of early and extended contact--and established a protocol for safe implementation in a hospital setting.[4] Measured under the purview of this study--before and after the variations in contact were experienced--were cognitive understanding, attitudes, and values related to child abuse; and mothers' attachment, closeness, confidence and idealization of the infant. There were no differences on these dimensions between time points, nor were there differences between contact groups on any of the dimensions studied.[5]

What might be surmized from these results is that although there are indications that early and extended contact bring about attachment and bonding, it is probably not a one-to-one relationship (the earlier and longer the contact, the stronger the bond), and is probably variable across populations. For instance, a very young mother in a non-supportive family situation may be more likely to "bond" with her baby if her own needs for nurturance are addressed after she gives birth than if she has the baby--and implied expectations--thrust at her immediately.

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[3] Grant #90-CA-2048, Department of Health and Human Services, "Collaborative Research of Community and Minority Group Action to Prevent Child Abuse and Neglect."

[4] Grant #90-CA-2138, Department of Health and Human Services, Demonstration of Early and Extended Postpartum Contact Between Parent and Newborn and Effects Upon Child Maltreatment."

[5] These statements of findings and those following are, of necessity, brief and unaccompanied by documentation. Readers interested in detailed presentation are encouraged to obtain the full research reports, itemized in Appendix B, from the National Committee for Prevention of Child Abuse, 332 South Michigan Ave., Suite 1250, Chicago, Illinois, 60604.

An extension of the early contact concept is that of the participatory birth experience. Advocated under this philosophy are the inclusion of the husband or another supportive person throughout the birth process; maximum participation of the mother in her own delivery; a recovery room equipped for a quiet time for mother, father and baby to spend together; rooming-in; and sibling visitation.

In a five-county area in Indiana, the Rural Family Support Project took a systems approach to encouraging this type of programming.[6] The process consisted of establishing Perinatal Planning Groups made up of obstetrical department supervisors, directors of nursing, social service and medical consultants, childbirth educators and community leaders: people who--although professionals in many cases--were volunteering their time to advocate and plan for changes that would help provide an optimum bonding experience for families.

It was found that these community organization techniques were quite effective in significantly altering the health care system as it relates to childbirth to make it more participatory and humane. Delivering mothers and their families were found to feel very good about experiencing childbirth in this atmosphere. The addition of most of the discrete changes and services however, was not shown to have a significant impact on mothers' closeness to the baby, or confidence in caring for the newborn. One exception is the private time between parents and baby after childbirth. Some association between this opportunity and increased closeness and confidence was found. Although short-term and lasting benefits for the child can be inferred from this association, this was not directly measured.

A third variation of the perinatal intervention theme is the array of educational and skill development interventions that can be made. Within this group of strategies there is available to the mother during the post-partum period a caring person who helps her learn what her baby can do and how to care for him. Particularly stressed here are support, education, and activities designed to foster the comfort and attachment between parents and child, such as discussion of the uniqueness of the particular child, demonstration of his response capabilities, and techniques to comfort him. The helping person, whether health professional or volunteer, is trained to be sensitive to and knowledgeable about the stresses childbirth creates for the mother and family and how to deal with them. The final step in this attempt to give parents and baby the best possible start together is a follow-up program to build on the relationship the mother began with the particular nurse or volunteer who offered her support and education during her hospital stay.

Perinatal Positive Parenting, a Michigan State University project was one such program.[7] In the hospital, information was dispensed by volunteers and by way of project-developed videotapes brought right into the mother's hospital room. Volunteers also made home visits to those who elected to receive them, where they demonstrated infant capabilities and infant stimulation activities and offered the parents an opportunity to discuss any questions or concerns they might have.

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[6] Grant #90-CA-2142, Department of Health and Human Services.

[7] Grant #90-CA-2137, Department of Health and Human Services.

Evaluation showed that these educational interventions delivered by supportive volunteers to first-time mothers were effective in reducing unrealistic expectations of their children. These volunteer services made strides toward reducing role reversal as well (the expectation of mothers that their babies would in some way take care of them). Idealization of the infant by the mother, however, was unaffected by these interventions.

The remaining perinatal strategy, which can be called perinatal support, combines elements of the other three, with an emphasis on reducing isolation and stress in the new mother, and compensating for nurturing skills and abilities in which she may be deficient due to her own early experiences. The Pride-In-Parenthood program in Norfolk, Virginia sought to provide support and education from a trained Family Friend (a project-trained paraprofessional) to Navy families and young inner-city couples about to experience parenthood for the first time.[*]

The program, chiefly through the efforts of the Family Friends, provided to its participants an opportunity for peer interaction and support by establishing groups of first-time parents. It prepared the participants for childbirth by encouraging them to take Lamaze preparation for natural childbirth classes. The program encouraged the father's presence during labor and delivery, and provided an opportunity for physical contact between parents and newborn to promote bonding. It provided education in child care. nutrition, and money management through the vehicle of the parents group. It linked parents up with community resources to provide them with recreation, social contacts, and self-development. The emphasis was on improving the families' chances for successful parenting by giving the parents coping skills and reducing their isolation. The one-to-one relationship with the Family Friend was critical.

Pride-In-Parenthood displayed weak, but positive effects from the program with measured differences in the mothers' attitudes towards their children, and improvement in parenting attitudes associated with abuse. The participants' enthusiastic support of the project was also thought to be an indicator of success, as it was part of the plan for perpetuation of the project that former recipients of the service would become Family Friends to other new parents.

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[*] Grant #90-CA-2139, Department of Health and Human Services.

Culturally Relevant Parent Education

Another area of child abuse prevention programming represented by two of the demonstration projects is culturally relevant parent education. Parent education is not a new concept; programs like P.E.T. and S.T.E.P. have enjoyed considerable popularity in the last decade. Culture-specific programs are a relatively new idea, however, with a logical connection to child abuse prevention. One application seeks to address the unique parenting problems of an ethnic and economic subculture in the United States, the other to deal with the special confusions and frustrations of an immigrant population.

The first is exemplified in Project C.A.N. Prevent, part of the Avance Parent-Child Education Program in San Antonio, Texas.[9] The Avance program was originally designed to aid Hispanic parents of low socioeconomic status in their efforts to help their children overcome problems in the school and society. The program takes a comprehensive approach to preventing and overcoming these problems, dealing with such environmental conditions as isolation, stress and economic status; and such psychological, cultural and educational processes as bonding and affection, discipline, and child growth and development. Project C.A.N. Prevent was designed to examine the above-mentioned forces and their effects through an extensive needs assessment in their target community and incorporate the results into a model 10-month parenting curriculum that they would then deliver to parents. Individuals were solicited for the program, were provided with home visiting and child care, and became part of the Avance "family."

The project intended to touch on every area of childrearing through their combination of didactic education, skill modeling, and supportive experience. In so doing, project planners hoped also to have an impact on the prevalence of child abuse and neglect in the population.

Indications are that their hopes were confirmed. The participants in this program were more knowledgeable in areas related to raising a child effectively, more positive in their childrearing attitudes, more willing and able to negotiate social support for themselves in times of stress, and more hopeful about the future after completing the program than they were before, and more so than mothers of a similar background who hadn't participated in the program.

In contrast to the total-immersion educational approach of Project C.A.N. Prevent, the Pan-Asian Parent Education project, under the auspices of the Union of Pan-Asian Communities, sought only to highlight the parenting issues of relevance to recently arrived members of four Asian ethnic communities (Japanese, Samoan, Filipino, and Vietnamese).[10] Specifically, the project set out to facilitate for the participants, development of insight into the role that cultural values and attitudes play in childrearing. The participants could thereby reduce the culture shock, disharmony in family life and socialization problems of parents and children that are so prevalent among new immigrants to a country. Conflict between parents adhering to their traditional parenting practices and beliefs and children who are rapidly "Americanizing" would be reduced by exposure to the parenting belief systems of both cultures and the opportunity to talk out the issues in the supportive atmosphere of a group, according to the tenets of this program.

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[9] Grant #90-CA-2143, Department of Health and Human Services.

[10] Grant #90-CA-2144, Department of Health and Human Services.

Evidence that these goals were reached includes positive participant feedback, changed attitudes and beliefs concerning some of the most problematic issues, and clearer conceptions by the participants of the differences between their culture and "mainstream American culture" with reference to childrearing. Responses to the group seemed to vary significantly according to the cultural traditions of the individual ethnic groups and acculturation levels of the members, however. Clearly, different groups wanted and got different things from the parenting group experience.

In addition to programs consisting of interventions with identified individual clients--i.e., parents of a specific culture, all new parents or first-time parents, there were programs in this demonstration effort that were aimed at the public in general. Two of these promoted public awareness and education using the media of live drama and videotaped dramatic presentations. They were Inter-Act: Street Theatre for Parents,[11] and the University of Mid-America's child abuse project, "Close to Home."[12]

Through Inter-Act, a troupe of actors dramatized original material for parents who do not, for a number of reasons, make use of traditional parent education services in a series of short, single-point sketches. The performers presented information on childrearing and coping skills in the hope of reducing family stress that might lead to abuse and neglect. Performances included topics such as stress management, diffusion of anger, realistic role expectations for family members, how to ask for help, and how to develop support systems.

The group performed in shopping centers, grocery store parking lots, military bases, low-income housing developments, employment service waiting rooms--wherever there are parents. Handouts were made available that described the main points of particular programs and provided information about resources for parents. Troupe members gave on-the-spot resource and referral information when it was solicited.

The skits were intentionally funny. Humor acted to diffuse the intensity of the subject matter, draw the audience into the performance and minimize the feeling on the part of the observers that they were being preached to.

Audience members were tested on attitudes targeted by these skits before and after the performances through an innovative nonintrusive design. Results were strongly positive: relevant attitudes changed significantly for each skit presented. For example, there was significantly less agreement with the statements, "Spanking is the best way to get kids to do what you want them to," and "You can't let children get away with a thing, or they will be spoiled" after seeing the skits than before. General audiences had more attitude change than audiences designated as "high risk" or "professional," although in the latter case this was because of a "ceiling effect;" that is, their scores were high to begin with. Whether the changes in attitude or acquistion of methods of coping with stress persist beyond the testing point was not addressed by the evaluation, but it is clear that a large number of people were reached and that they "got the message" the project was sending.

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[11] Grant #90-CA-2177, Department of Health and Human Services.

[12] Grant #90-CA-2141, Department of Health and Human Services.

"Close to Home" is a filmed mini-series of three half-hour dramatic pieces with interwoven characters dealing with three important issues for parents: What can I realistically hope for and expect from my child; How can I handle those difficult, highly stressful times when nothing's going right; How can I deal with changes that seem too many and too fast?

The University of Mid-America chose these issues because most parents find them difficult at one time or another. Unrealistic expectations, high-stress situations, and disturbing changes are often at the root of family crises. And they are key elements in many cases of child abuse or neglect.

Their purpose in producing these films was not to point an angry finger at parents who fail. Each film tells the story of a parent and a family in difficulty. No character is perfect, but nobody is a villain either. Like most parents, the mothers and fathers in the films are concerned about finding better ways to live together in a family. Like most parents, they are still learning to commnuicate with each other and with their children. Like all parents, they sometimes make mistakes; but they also succeed.

The "Close to Home" films were shown to varied audiences that were culturally diverse and included many first-time and teenage parents and pregnant adolescents as well as child welfare social workers, teachers, and health care professionals. The audience responses to the three segments of the series were, on the whole, positive, although not uniform across segments. The stories engaged the attention of the viewers, elicited strong feelings and stimulated discussion. Some short-term attitude change was evidenced, although not to a statistically significant degree. The films were accepted by diverse racial and cultural groups as being appropriate, for the most part. Several agencies involved in the evaluation phase expressed interest in having the tapes available to them for use with client groups as a focus for discussion and learning.

Community-Wide Education, Information and Referral Projects

There were three other programs benefitting whole communities in this demonstration round. Programs in this group sought to provide parent and family education and courses on childrearing skills for adults through public schools and community education methods; strengthen informal helping networks through the improvement of information and referral services, and mount public education regarding family support resources through the public media. The programs funded to demonstrate this approach all served unique communities. The first served the largely rural island community of northwest Washington State; another served the Blackfeet Indian Reservation in Browning, Montana and a third related to the three most impovershied black census tracts in Atlanta, Georgia.

In many ways these programs were the most ambitious of the demonstrations. Changing whole communities is a tremendous task, and the likelihood of their impact being widely recognized is slim. The drawback is exacerbated by two facts about community based prevention programs: 1) it is widely accepted that "community ownership" of the goals and methodology of community change is an essential component of significant change at the community level and 2) it is difficult to measure the effectiveness of programs with the community as their target.

Community ownership was an issue for each of these programs in a different way. The Cascade Islands (Washington), Primary Prevention Partnership[13] project, sought to increase the awareness of both the professional and lay community, to initiate and strengthen services aimed at reducing personal and family stress, and to coordinate and unify the matrix of community providers into a cohesive system. However, very early in this demonstration, the largest and most sophisticated of the four project counties began resisting the project's networking attempts. As a result, the project largely circumvented that county in their ensuing efforts. In spite of this, it can be said that the project effected substantial change in its catchment area during its operation.

For the Blackfeet Indian reservation and the inner-city Atlanta census tracts that made up the catchment area of Project Network, community ownership issues were of another sort. Both these severely deprived communities were somewhat accustomed to having outside programs--particularly government programs--thrust upon them. For the most part they had felt no ownership of these programs whatsoever. They were skeptical and without hope in regard to these new interventions.

The projects took very different tacks with these two communities, however. Although the Blackfeet Child Abuse Prevention[14] project was operated exclusively by the Blackfeet Indians, and was in that sense "owned" by the community, the model was a professional and an authoritarian one. The project staff mounted an extensive public awareness campaign telling community members what they were doing wrong in raising their children. The material was straightforward, and focused on negative parenting practices.

In contrast, Project Network[15] was acutely sensitive to the history of short-lived and marginally helpful programs imposed on their target community, sought to provide a quite different experience. Perhaps this task was made more difficult by the fact that this project, although located in the target community, was a cooperative venture between Atlanta University and the Department of Family and Children's Services. Community representation was built into the team approach by employing a resident counselor from each census tract, but the largest part of the educational and counseling interventions were provided by graduate students.

Community ownership was incomplete at the end of the funding period for this this project, but this goal was still being worked toward after funds were expended. Significant is the fact that rather than being a natural outgrowth of the participatory and helpful experiences community residents had through Project Network, community ownership was something for which this project had to draw up detailed plans, left for the community in the form of a volunteer training manual at the end of the project.

That all three of these community education/information and referral programs accomplished some of their goals in educating their target populations and networking the existing agencies in their catchment areas is indisputable. The Cascade Islands project (Primary Prevention Partnership) made over

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[13] Grant #90-CA-2141, Department of Health and Human Services.

[14] Grant #90-CA-2145, Department of Health and Human Services.

[15] Grant #90-CA-2146, Department of Health and Human Services.

50 presentations to the public at large and distributed 15,600 copies of project-developed materials. They planned, provided, coordinated and/or co-sponsored at least 160 in-service training sessions, workshops and conferences to members of the provider community. They were instrumental in developing continuing education and core college courses on child abuse and neglect and family stress-related subjects that ran in seven 10-session courses and educated 195 teachers. I&R systems were developed in two of their target counties during the project period. Community impact interviews indicated an overall assessment of increased personal knowledge on the part of the professional community, increased public awareness about child abuse and neglect, improvement in the coordinator and referral network among service providers, and increases in the kinds of services offered for the treatment of prevention of child abuse and neglect.

The Blackfeet Child Abuse Project developed and extensively disseminated materials on child abuse and neglect to the lay community via the major service providers in the legal, health, education and welfare systems. They introduced several innovative outreach efforts to involve community members in participatory parent-child activities. Principal representatives of the legal, health, education and welfare system expressed the opinion that community awareness of the causes and effects of child abuse and neglect increased during the period the project was in operation.

In addition, the Blackfeet project staff participated in significant and continuous roles to: implement the Indian Child Welfare Act in the removal and placement of Blackfeet children; negotiate agreements between the Tribe and State Social and Rehabilitation Services for foster home liscensing and financial responsibility in the placement of abused, neglected and dependent children; and provide an alternative to jail for non-criminal juvenile offenders.

Project Network provided preventive counseling services to 28 families, trained numerous community and outside professionals in child abuse and family stress issues, educated community parents in many areas of childrearing and coping techniques, and produced and disseminated an extensive directory of services for children and youth. Through establishing its credibility with community residents as well as with agencies and institutions serving the community, the project showed that while the services currently available might not be adequate, they could be more effectively utilized through project mediation.

The effect of the efforts of these three projects on the lives of the individuals in these areas must remain unclear, however. Child abuse rates cannot be considered a yard stick because reporting (and undoubtedly incidence) of child abuse is increasing nearly everywhere, and indeed reported cases rose in all three of these communities over the project time period. (In some instances this may actually be a good sign of increased awareness and less reluctance to report appropriate cases.) Controlled studies are not feasible on the cross-community level, particularly with communities as unique as the Blackfeet reservation. Even pre- and post-testing of individual educational efforts gives only a short-range indication of effect and is complicated by the diversity of educational presentations presented by each program. At best we can only infer from community impact interviewing the difference these extensive efforts will actually make to particular families and in the overall incidence in the long run.

Without massive and costly epidemiological studies, programs of this sort will continue to be undertaken on their face validity. They will be evaluated largely on the basis of whether they performed the activities they said they would, and on the basis of the opinions of key community informants as to their effect. Whether the community comes to "own" the objectives and techniques of the projects will weigh heavily in the final decisions about their effectiveness. Perhaps more so than with any of the other kinds of demonstrations in this prevention program, the reader will make his own determination as to whether the community-based programs "worked" as child abuse prevention strategies.

Conclusion

What, then, have we learned from these eleven projects? These data, when considered in the context of their precursors, suggest that bonding and attachment are much more complex phenomena than we might otherwise have thought. Although providing the accoutrements of family-centered, humane childbirth may contribute to reduced parenting disturbance for some, systematic changes in medical institutions and those services that surround them are probably inadequate to effect the essential relationship between parents and children in the aggregate.

This is true also of provision of early and extended contact arrangements in the hospitals. Very specific effects, but in different directions, may have cancelled one another out in these analyses, producing the nondramatic results. Who the participants are, and what they bring to the situation in the way of strengths, environmental supports and background, clearly should be taken into account in planning these kinds of programs. First, however, the relative influence of these characteristics and situational elements on the ability to benefit from such programs must be determined.

Another thing we learned from these demonstrations is that education can be effective in altering parenting attitudes. In the perinatal hospital environment, the post-partum home environment, and the didactic group setting, attitudes known to be associated with child abuse and neglect were lessened. It is essential to realize, however, that in every case this education was dispensed within a supportive relationship; and in most cases it was a one-to-one relationship. (Remember that measurable attitude change in parents was largely absent in the program that made extensive institutional changes, but did not assign particular helping persons to the families served by that system.)

Perhaps this is simply the replacement of a phenomenon that used to exist in our society through the extended family--the young woman being empathically taught how to be a mother by her own mother. Perhaps it more resembles the natural helping relationship that would exist in communities and neighborhoods before these environments disappeared for some people. Or perhaps the model is more one of mentoring, also a natural relationship for those with access to a potential mentor. In any case, it is the naturalness, the meeting of several needs simultaneously, the reciprocity of benefit for mother and volunteer that seems to be the successful factor in this prevention method.

We learned that prevention of child abuse programs can be conducted at the local level. With the exception of the two university-run projects (and one of these was actually conducted in a defined community, some distance from the university), these programs took on rather ambitious goals without relying on extensive bureaucracies and the budgets that go with them. Part and parcel of this finding is the comfirmation that paraprofessionals and volunteers are accepted and effective in delivering supportive and educational programs to individuals on a preventive basis--that is, to people who have neither been identified as having a need, nor sought out any kind of service. It had been reasonably well established that lay counselors and lay therapists are an efficient and effective addition to treatment programs (see, for example, Cohn [10]); but the intuition that they would be effective in prevention programs stood in need of empirical corroboration.

We learned that the demonstration project structure (coupled with the state of the art of evaluation research in prevention) is, for the most part, inadequate to measurably affect the quality of family life for whole communities. In many ways, information and referral and community education programs raise community expectations about continuing services that often cannot be met beyond the demonstration grant period.

We learned that the creative arts are effective communicators of preventive information; that they stimulate discussion of meaningful topics, allow the introduction of highly sensitive material and facilitate the reaching of large numbers of people, including groups traditionally thought of as inaccessible.

There are, of course, many things the research of these demonstrations did not tell us. We do not know about the individual and subgroup variation in susceptibility to these programs (although the data exist to investigate this). In both the highly and the less-successful programs there are classifications of people who do better or worse than others; who they are and why they were affected in a particular way are significant questions to pursue further.

We do not know how lasting any of the effects of these programs on parents will be beyond the final measurements. There was little opportunity for longitudinal follow-up in this study, and the changes measured one day could conceivably have disappeared the next. Moreover, we do not know that any of these programs prevented child abuse that would have occurred without them. Long-term prospective research is the only way to come close to answering that question, and even that cannot tell us who would have abused their children. Proximate measures of effectiveness are nearly always the best outcome that can be obtained for prevention programs of this nature [10].

Finally, we do not know about the generalizability of these programs. Can these results be replicated elsewhere, or are they simply artifacts of these particular conditions? These are all valid questions that should be studied. For the time being, some of these strategies look promising. There is reason for the community in general and, in particular, members of those professions and systems that can no longer adequately treat child abuse after the fact, to advocate for their continued operation and evaluation.

Recommendations

On the basis of the experience of observing and evaluating these eleven demonstration projects over the course of three and a half years, a number of recommendations can be made to NCCAN and to the research and demonstration generating and funding community outside of the government. The first class of these recommendations has to do with programming. We can recommend a number of program types to be undertaken at the community level and funded by NCCAN and others. One type of project recommended is programs responsive to particular cultural groups. Programs that will develop specific techniques and materials for one or a few related cultural groups are necessary and can add substantially to our overall knowledge of how to deliver preventive interventions. The Pan Asian Parent Education Program demonstrated the vast differences between groups often perceived as one (Asians); and that program and, to a greater extent, the Avance C.A.N. Prevent program showed that a culture-based program can be very powerful in transferring knowledge and changing attitudes.

We would also recommend conducting programs where volunteers or para-professionals work one-to-one with parents, perhaps extending the contact point beyond the perinatal period to other points in the life cycle. These parent aides could work with families during the child's preschool period, for instance, perhaps making contact through well baby clinics or day care centers. Families of school age children could be contacted through the schools. Extending the concepts of parent education and support delivered in the context of a special empathic relationship later in the life cycle would make that service available to those who may not have had access to supportive perinatal experiences and it would provide a "refresher" experience for some parents--something that may be needed due to the shifting needs and concerns stimulated by children's passage through developmental stages no matter how helpful a perinatal program may have been.

Our third recommendation would be that there be more programs demonstrated employing the entertainment media and using concepts from theatre and television. These media and the techniques associated with them could be applied to problems of neglect as well as abuse, and would be particularly suited to dealing with specific and timely environmental stresses related to child abuse: unemployment, depression, divorce, single parenthood. The ability of the mass media and the entertainment format to engage otherwise unreachable segments of the population augers for their increasing utilization in preventive efforts.

Further research of several types is also suggested by this evaluation. The first type indicated is epidemiological study. Many potentially helpful findings have come out of such studies that could have an impact on our thinking about child abuse prevention (e.g. the findings regarding high risk neighborhoods [11] and the impact of changes in the work force size [12]). We need to continue to refine our knowledge of the correlates of child abuse, the demographic variations, attitudes, behaviors and social conditions that accompany high rates of child abuse, so that they can be targeted by prevention programs. Hand-in-hand with these efforts would be methodologically sound needs assessment surveys of well-defined communities such as that conducted by Project C.A.N. Prevent in San Antonio, yielding even more specific information about risk factors.

Follow-up studies must be advocated. The strategies represented by this demonstration program that were found to be successful as well as others must be followed through the period of risk for child abuse--in many cases this would be the duration of childhood--rather than just through the most opportune period for intervention and evaluation. This research includes both assessing the longevity of the proximal goal attaiment, such as attitude change, as well as linking the immediate goals with the ultimate reduction in child abuse. Studies such as those represented by this collaborative research effort are only a first step toward these longitudinal research endeavors, but they should be utilized as this first step and not considered to be ends in themselves.

We need comparative studies of prevention strategies. Successful elements of prevention programs can be identified by studies such as this one. Determining what combinations of these elements are most effective in reducing the incidence of child abuse is a necessary outgrowth of this research. This harks back to the necessity of tailoring prevention programs to the particular characteristics of communities. In those areas where we have seemingly conflicting results from evaluation research, such as the studies on the phenomenon of "bonding" and the contributions to it made by such interventions as early and extended post-partum contact, in depth cross-program study is recommended to determine the ability of different program elements and combinations of them to affect the parent infant relationship and the risk for abuse given varying environmental conditions and client characteristics.

An important consideration is that of cost effectiveness. Although most of the interventions offered through this demonstration program are relatively inexpensive, they are not of equal cost, even if they were equally effective. Cost effectiveness measurement technique can be applied to prevention efforts [13], and they should be included wherever possible in assessing the relative value of different service mixes in preventing child abuse and neglect.

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Community and Minority Group Action to Prevent Child Abuse and Neglect Demonstration Projects

Perinatal Programs

Demonstration of Early and Extended Postpartum Contact Between
Parents and Newborn and Effect upon Child Maltreatment
Vanderbilt University School of Medicine
Nashville, Tennessee

Objective:

1. To develop three types of increased post-partum contact between parent and child, determine the frequency of child maltreatment after each type of contact.
2. To establish a protocol by which early and extended contact can be implemented in a general hospital setting without undue disruption of staff or harm to the infant.

Perinatal Positive Parenting
Institute for Family & Child Study
MIchigan State University
East Lansing, Michigan

Objective: To provide new parents with volunteer support and information/referral on parent-child relationships, early child growth and development, existing community resources and activities, toys, materials and books about their newborn; limited modeling of the skills needed to care for an infant; and the opportunity to interact with other new parents and to share their needs and concerns.

Rural Family Support Project
Quinco Consulting Center
Columbus, Indiana

Objective: To prevent child abuse and neglect by promoting a healthy parent child bond, attachment, and relationship through the provision of a supportive perinatal environment and continuing services for rural families.

Pride in Parenthood
The Planning Council
Norfolk, Virginia

Objective: To demonstrate the effectiveness of a primary prevention of child abuse program delivered by a trained parent aide to first-time parents beginning in the prenatal stage, containing a perinatal bonding component, and lasting approximately through the baby's ninth month of age.

Parent Education

Project C.A.N. Prevent
Avance Parent Child Education Program
San Antonio, Texas

Objective: 1. To identify factors and conditions that may be indicators for potential child abuse and neglect among low SES Mexican-American mothers.

2. To develop a comprehensive parenting education mode which is responsive to the needs of the identified target population and which address the prevention of child abuse and neglect.

Pan Asian Parent Education Project
Union of Pan Asian Communities
San Diego, California

Objective: 1. To provide primary prevention of child abuse services for various Pan Asian ethnic communities, including Japanese, Samoan, Filipino, and Vietnamese, and to provide each participant the opportunity to learn about the similarities and differences in childrearing and socialization between their cultures and the mainstream culture.
2. To develop material about each of the target groups to include a description of values and attitudes toward children, the role and relationship of childreen in the family and extended family, childrearing practices and coping skills to be used for cultural awareness training. To develop a primary prevention guide for use with Pan Asian American parents.

Media

Close to Home
Primary Prevention of Child Abuse Television Programs
University of Mid-America
Lincoln, Nebraska

Objective: to produce a series of three half-hour television dramas for broadcast on public television networks and videotaped for use with parent training and other education groups. Stories will highlight aspects of normal family life which are stressful and can lead to child abuse, and offer some coping suggestions. Print materials will be developed to accompany videotapes for education groups.

Inter-Act: Street Theatre for Parents
Panel for Family Living
Tacoma, Washington

Objective: To reduce the possibility of child abuse and neglect by taking theatre presentations incorporating information on childrearing and coping skills to hard to reach parents. to offer: a) grassroots outreach to people who normally do not utilize conventional parent education services; b) information and modeling skills in a way that people can easily absorb and use; c) parents a chance to help themselves by providing alternatives to negative or damaging parent behavior.

Community Awareness/Information and Referral

Blackfeet Information and Referral Project for the
Primary Prevention of Child Abuse and Neglect
Blackfeet Tribe
Browning, Montana

Objective: To develop an awareness in the Blackfeet reservation community about child abuse and neglect and to enlist community agents to work cooperatively to a) maintain this awareness and b) participate in child abuse and neglect prevention activities, which will include presentations to schools and other community groups, personal awareness conferences, and parenting classes.

Primary Prevention Partnership
Cascade Islands Comprehensive Community Mental Health Center
Mt. Vernon, Washington

Objective: Education of multiple professional groups (e.g., education clergy, medical) in a four-county rural area as to the incidence of child abuse in the area, case identification, proper response and techniques for prevention. Development of an information and referral system which will be accessible to all professional and supportive services to families in the project catchment area.

Project Network
Atlanta Univeristy School of Social Work
Atlanta, Georgia

Objective: To build a comprehensive community network to support families in the prevention of child abuse and neglect through the formation of task forces, parent groups, and an information and referral system. To offer community education, parenting skills training and preventive counseling of individuals.

Documents Related to the Collaborative Research of Community and Minority Group Action To Prevent Child Abuse and Neglect

Final Report: Collaborative Research of Community and Minority Group Action to Prevent Child Abuse and Neglect, National Committee for Prevention of Child Abuse, 1983.

Volume I	Perinatal Interventions
Volume II	Culture-Based Parent Education Programs
Volume III	Public Awareness and Education Using the Creative Arts
Volume IV	Community-Wide Education, Information and Referral Programs

Child Abuse Prevention Project Profiles (interim document), National Committee for Prevention of Child Abuse, 1981.

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"Ethnocentric Perceptions of Childrearing Practices in Protective Services," with John Cosgrove, *Child Abuse and Neglect: The International Journal*, Vol. 7, No. 4, 1983.

PREPARED STATEMENT OF THE ALCOHOL AND DRUG PROBLEMS ASSOCIATION OF NORTH AMERICA

This statement is in response to congressional hearings held by the House Select Committee on Children Youth and Families concerning the prevention of child abuse. It presents the concerns of the Alcohol and Drug Problems Association of North America, (ADPA), regarding the relationship between child abuse and drug and alcohol abuse. ADPA welcomes this opportunity to express its views on this important societal issue to the committee.

ADPA was organized in 1949 as a national association of state officials responsible for alcoholism programming in each of their respective states. In recent years, ADPA has broadened its efforts to include all those professionally engaged in the alcohol and drug abuse field. Accordingly, our members now consist not only of state officials, but also representatives of community based treatment, prevention, education, and research agencies, as well as individual professionals and others interested in the alcohol and drug field. Over 9,000 professionals are represented by ADPA.

Child abuse is a major problem in the United States, although the number and severity of child abuse cases per year is unknown due to the reluctance of its victims to report each incident. Numerous studies do indicate that there is a significant relationship between alcohol, other drug abuse and child abuse. But again, because of inadequate research and data, this relationship is unclear. It is estimated, however, that alcohol may play a role in one-third of all reported cases of child abuse.

Incidents of family violence, ie. child abuse, will not be reduced unless the alcohol or other drug problem is treated. This concept is evident in data provided by the National Institute on Alcohol Abuse and Alcoholism. An analysis of the National Alcohol Profile Information System data, retreived from almost 500 NIAAA-funded treatment programs, shows that thirty-five percent of persons entering these programs reported fighting and quarreling with others as a measure of their behavioral impairment. Six months after entering the program, there was a reduction of thirty-nine percent in the number of people reporting this behavior (1978). Therefore, there is some indication that treatment for alcoholism can reduce violence by alcoholics.

Treating the alcohol or other drug problem will not neccessarily stop the violence. However, it is easier to address the violence if the alcohol or other drug problems are resolved first. According to Lt. Commander Daniel W. Behling of the Naval Regional Medical Center in Long Beach CA., "Unless the alcoholism is treated, any apparent success in case management will be temporary and 'bandaid' treatment at best." In addition, Mayer and Black (1977) have found that alcoholics who were being treated for their alcoholism were able to recognize the potential for abuse of their children and to develop ways to deal with situations which might lead to abuse.

National and State efforts to address the problem of child abuse must take into account the family history of alcohol and other drug abuse. Social service agencies, hospitals, alcoholism treatment programs and shelters are not recognizing this imperative relationship. According to Margaret H. Hindman in her article on family violence, "Few services aimed at abused children and battered wives focus on alcohol involvement. Even in cases where the abuser is identified as an alcoholic, the issue of treating the alcohol abuse is not always pursued. This functions as a serious barrier to treatment in the view of some professionals."

ADPA has several recommendations for responding to child abuse and alcohol/drug problems:

The Federal Government should take a leadership role by funding programs which:

1. Provide training for substance abuse professionals and child abuse professionals on the interrelatedness of these two issues;
2. Provide training for health and social service professionals in the identification of alcohol and drug problems in child abuse situations;
3. Provide demonstration programs to test various models that provide a comprehensive approach for treatment of families where alcohol/drug problems and child abuse are present;
4. Provide research which explores the relationship between alcohol and other drug usage, alcoholism and drug addiction and child abuse;
5. Support programs to increase volunteer efforts in addressing child abuse problems.

The Federal Government should recommend to states that they:

1. Develop licensure standards for alcohol/drug treatment programs requiring that they have cooperative agreements with local child abuse programs, have appropriate intake questions to determine the possibility of child abuse

and require training for staff on issues of child abuse;

2. Develop licensure standards for child abuse treatment programs requiring that they have cooperative agreements with local alcohol/drug treatment programs, have appropriate intake questions to determine the possibility of alcohol or drug related problems and require training for staff on issues of alcohol and/or drug problems.

In conclusion, ADPA urges the committee to see the treatment of alcohol/drug abuse problems as an integral part in the prevention of child abuse. It is known that there is a definite association between these two issues. If we are to see the eventual decline in child abuse incidents, we must start with the treatment of the abusers, who often have an alcohol and/or drug abuse problem. Early identification of drug abusers and alcoholic child abusers will provide the abuser with a quick placement in a treatment program which integrates exploration of the connection between alcohol and violence. In addition, the child victim will be more quickly referred to the social service or other appropriate agency for interventive action, thus insuring safety for the child.

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May 1, 1984

Ms. Johanna Schuchert
Director
Parents Anonymous of Virginia
1212 Wilmer Avenue
Richmond, Virginia 23227

Dear Ms. Schuchert:

This is to express my personal appreciation for your appearance before the Select Committee on Children, Youth, and Families at our hearing, "Child Abuse: What We Know About Prevention Strategies," held in Washington on March 12. I regret my schedule did not permit me to be there, but I know from reading the transcript that your participation contributed greatly toward making the hearing a success.

The Select Committee is now in the process of editing the transcript of the hearing for publication. It would be helpful if you would go over the enclosed copy of your testimony to assure that it is accurate, and return it to us with any necessary corrections.

In addition, Representatives William Lehman and Thomas J. Bliley, Jr. have submitted questions and asked that they be answered for the hearing record:

Congressman Lehman

1. How are volunteers used in your community programs to address specific child abuse crises and the associated family and environmental stresses that might have led to abuse?

2. In what ways do your programs work with local agencies and private providers to reach and serve abusing or potentially abusing families? Why is that cooperation and networking important, and how has it been achieved in your community?

Congressman Bliley

1. In your testimony, you argue that parenting classes will do the abusive parent very little good if his emotional needs are not met first. Yet many programs seem to be based on the idea that giving parents these classes will help them to gain the positive self-image necessary for good parenting. Could you comment on this difference in approach?

2. What kind of family life education would you like to see implemented in the schools? You have said that these classes would be neither sex education nor the teaching of morals. What would they include?

3. You have said in your testimony that you often find yourselves trying to write grant proposals with a new twist, just in order to catch someone's eye. Do you believe that there has been a disproportionate amount of emphasis give to coming up with "new and innovative" approaches?

4. How does the $75 per family cost of Parents Anonymous compare with other approaches available to parents in Virginia? How does the Parents Anonymous success rate compare with that of other available programs?

Let me again express my thanks, and that of the other members of the committee, for your testimony.

Sincerely,

GEORGE MILLER
Chairman
Select Committee on Children,
Youth, and Families

GM/j

Enclosures

PARENTS ANONYMOUS of VIRGINIA, Inc.
Identification - Treatment - Prevention of Child Abuse
1212 Wilmer Avenue
Richmond, Virginia 23227
(804) 264-2901

August 10, 1984

Congressman George Miller
Select Committee on Children,
Youth, and Families
Room H2-385 House Office Building
Annex 2
Washington, D.C. 20515

Dear Congressman Miller,

I am writing in response to the questions contained in your letter dated May 1st. Thank you for your interest and the opportunity to respond to additional questions.

Congressman Lehman

1. Trained volunteers are available by telephone 24 hours a day, to parents in crisis. Their responsibility is to listen to the parent and offer resources to help meet his needs. If the parent attends a local chapter he/she also has the other parents available to him as well as professionally trained volunteers, called sponsors, who work with the chapter. These services help break family isolation and build self-esteem.

   In conjunction with chapter meetings, volunteers also provide transportation for families to Parents Anonymous meetings. Parents in the chapters are encouraged to carpool whenever possible.

   Sponsors will also make home visits if necessary to deal with crisis situations. They may transport parents to doctor appointments or to the hospital in emergencies. Most offer additional supportive service to parents or connect them with agencies who can help, as well.

   Trained volunteers also provide services to children through various play therapy and teen support programs. Most meet weekly for at least two hours. Volunteers for the teen programs are usually available by telephone during the week for crisis counseling.

   Some Parents Anonymous organizations sponsor and/or maintain crisis nurseries which give parents time out from the children as an alternative to abusive situations.

The availability of volunteers in the manners described, serves to provide alternate channeling of stress and anger into more appropriate outlets. The networking initiated by P.A. volunteers helps create a stronger support system for families under stress, thus building trust in the community.

2. If communities are to adequately serve multi-problem families, each agency in the support system must be aware of what the others are doing, so as not to confuse families with conflicting advise or dilute the effectiveness of others' efforts. This networking effort helps families build trust when they see agencies working together for their benefit, and also aids agencies through mutual cooperation. However, there are many barriers to this concept: turfism, confidentiality, lack of communication and lack of trust. Our strategy in Virginia has been that of developing personal relationships with the directors and staffs of public and private agencies. Our feeling has been that if a trusting relationship can be established through personal contact, then communication will develop, turfism will diminish and confidentiality issues can be worked out cooperatively.

   We have endeavored to become aware of agencies' needs and whenever possible we have offered to help. (ie: free staff training, serve on boards and multidisciplinary teams, resource for speaking engagements, etc.)

   When working with state agencies we use the approach of getting to know the state level staff and asking them to encourage their local people to use our services or help establish P.A. chapters if none exist.

Congressman Bliley

In regard to family life education curricula in schools, the Virginia Department of Education does not mandate the teaching of such curricula in Virginia schools. The Department has just published a booklet entitled, "Family Life Education - Curriculum Guidelines", but does not advocate implementation. They leave the decision entirely in the hands of local school boards. Independent living skills are a major part of what should be taught. The Department states in the booklet, "Community interests and values may prevent some school divisions from using some of the content contained in the instructional sheets".

The State School-Age Parents Committee on which I serve deals with issues relating to teenage pregnancy and parenthood. A member of this group, Ben Greenburg, drafted legislation last year which would mandate schools to teach some form of Family Life Education.

HJR 154 was carried over to the 1985 General Assembly session. Many people see the value of teaching children how to be independent, responsible, caring adults, within our school system. Remember parenting is the most difficult job in the world and the one for which we receive the least amount of training.

In regard to the question concerning funding: More organizations need funding than there is public or private money available. Therefore, criteria have been established to aid with the allocation of funds. However, most public and private criteria include guidelines for "new and/or innovative ideas or approaches". Most want to provide seed money to get a program started. Funds to keep a successful program going are few and far between. Competition for funds has partially created this problem. The Federal Register demonstrates this philosophy. I feel federal money should be divided to insure the survival of those programs which have proven successful. Of course, funds need to be available for developing more and varied approaches to societies' multitude of needs. But, private non-profit organizations like Parents Anonymous, must be given consideration by public and private funding sources if we are to continue the high quality programs we now have.

Sincerely,

Johanna Schuchert

Johanna Schuchert,
Executive Director
P.A. of Va., Inc.

JS/afp

cc:

Enclosure

ADDITIONAL RESPONSE BY MS. JOHANA SCHUCHERT

In regard to the question concerning parenting classes and their usefulness for parents with problems:

First, let me state that this was not a blanket statement. However, the majority of parents we serve don't have the ability to see past their own needs. This is because many of their *basic* emotional needs for acceptance (love and nurturing), security, trust, freedom to be who they are, etc. were never met. Until you experience those positive feelings, the taking on of academic information and ability to care about meeting the needs of others become low priorities. So, expecting people to learn skills in a parenting class to help respond to their children's needs, when they are still trying to get their own needs met has not proven very successful. This same phenomenon can be observed in abused children: One of the first indicators we may be aware of in indentifying an abused child (one who is not getting emotional or physical needs met) is dropping school grades. If that child receives no intervention he will grow up biologically but not emotionally. He will still be trying to find himself and may continue to do badly in school; may drop out; may not be able to hold a job; may get into delinquent behavior, drug or alcohol abuse, etc. This child my become a parent and develop parenting problems. It is likely that he will not seek a parenting class or drop out if he starts. What he needs first is some reparenting.

Concerning the question of the effectieness of the P.A. approach and the low cost of service: Three national studies have been conducted regarding the success of the P.A. approach. All three concluded that P.A. is the most effective treatment resource of its kind, especially when used in conjunction with a parent aid program which is also seen as an effective treatment method. The three studies were done by Behavior Associates, Tuscon Arizona; Berkeley Planning Associates, Berkeley, California; and Health and Human Services. I am not aware of any studies which have been done on the State level in this area.

The cost effectiveness of Parents Anonymous vs other major providers of treatment is as follows:

Parents Anonymous—no fee; $75 per year per family.

Family and Children's Service—sliding scale, fee $1-$40 per hour per person.

Public Service Agencies figures not available at this time.

Private Therapy—$40-$75 per hour per person.

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